DEPT.- 65

JOB- 21

REEL- 49

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer, Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force 3/28/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79031 D79031

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 W. North Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Livingood

(a) RESIDENCE NO. 2707 W. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Clare

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Heater

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Plate Plant

(c) Name of employer Bethlehem Steel Corporation

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER David P. Livingood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Belle Riderbush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Mrs. Lilian Zollinger 2707 W. North Ave.

15 Filed ..., 19... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 - 1923, to Sept 10 1923, that I last saw him alive on Sept 10 1923, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Gastritis Chronic

(duration) 2 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 1922 —

Was there an autopsy? —

What test confirmed diagnosis?

9-10-23 (Signed) E. H. Wagner M. D.

(Address) 1302 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 11 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Calvert St

SEP 11 1923 Robert P. Harrison, Burial Permit Clerk.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79032

D79032

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Love

(a) Residence No. 5 N. 11th st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6-DATE OF BIRTH (month, day and year): 1883 ?

7-AGE: 40 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS

10-NAME OF FATHER: George R. Love

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Gollery

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed ..... 192 ..... Registrar.

SEP 11 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 10, '23

17- I HEREBY CERTIFY, That I attended deceased from Aug. 26 19 23 to Sept. 10 19 23

that I last saw h.im alive on Sept. 10 19 23

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D

9-11-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Sept 12, 1923

20-UNDERTAKER: Jos Joerdens & Son ADDRESS 217 S. Pace

N. B.—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH is very important. See should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79033

CERTIFICATE OF DEATH.

118-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Lemont St.; 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rollins Johnson.

(a) RESIDENCE. No. 1323 Lemont St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct - 1819

7 AGE: Years 4; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Rollins Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lizzie Johnson

(Address) 1323 Lemont St

15 Filed ——— 19 ———

Registrar

SEP 11 1923

Robert P. Harriden

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1923, to Sept 9, 1923, that I last saw him alive on Sept 9th, 1923, and that death occurred, on the date stated above, at 10:26 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteric Intoxication (Paralytic Ileus)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) ——— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms only

(Signed) C. N. Griffith, M. D.

, 19 (Address) 132 N Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 11 19

20 UNDERTAKER: Brown & Fredericks — ADDRESS: 1145 Sept 11

Spec.-12-23-21-E.B.R.S.-400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79034

CERTIFICATE OF DEATH.

D79034

✓ O.K. 10 AK Jones

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 741 W. Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Thelma Elizabeth Rogers

(a) Residence No. 741 W Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F.	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jan 9 - 1921

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
2 yrs. 7 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Savannah Ga
(State or Country),

PARENTS.

10-NAME OF FATHER, Riley Rogers

11-BIRTHPLACE OF FATHER (city or town) Savannah Ga
(State or Country),

12-MAIDEN NAME OF MOTHER, Lillian S. Richardson

13-BIRTHPLACE OF MOTHER (city or town) Savannah Geo
(State or Country),

14- (Informant) Riley Rogers

(Address) 741 West Lexington St.

15- Filed, ..., 192..... Registrar.

SEP 11 1923 Robert P. Harrison, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 10, 23

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923 to Sept 10, 1923

that I last saw her alive on Sept. 10 1923

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Laboratory

(Signed) Henry A Weinberger M. D.

Sept 11, 1923 (Address) 724 N. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 12, 1923

20-UNDERTAKER. Wm Cook 502 East North Ave ADDRESS

N. B.—WHITE... should be carefully supplied. AGE should be stated EXACTLY... Exact statement of OCCUPATION is very important. See... in plain terms, so that it may be properly classified. ...instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79035

CERTIFICATE OF DEATH.

146

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 - Temple ST., 2 WARD)

2-FULL NAME Mary Goins

(a) RESIDENCE NO. 8 - Temple ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	21	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER John Goins

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant John Goins
(Address) 8 Temple.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10- 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-5- , 1923 , to 9-10- , 1923, that I last saw her alive on 9-10- , 1923 , and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos 35 ds.

CONTRIBUTORY (Secondary) Child birth (August Term)

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Cargill, M. D.

9-11-, 1923 (Address) 611 - N - Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Peterburgh, Va.

DATE OF BURIAL Sept. 12, 1923

20 UNDERTAKER Robert T. Williams

ADDRESS 1513 McCulloh St

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert P. Harrison,
Burial Permit Clerk.

Sep 11 1923

Spec.—1-10-21—M&T—1500 Bks.

D79036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79036

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Greenmount Ave. WARD) 10

2-FULL NAME Patrick Dolan

(a) RESIDENCE NO. 1036 Greenmount Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Dolan

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. C. Windfield

(Address) 914 Greenmount Ave

15 Filed ..... 19 ..... Registrar

SEP 11 1923 Robert F. Harrison, Postal Record Clerk

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1923, to Sept. 11, 1923, that I last saw him alive on Sept 11, 1923, and that death occurred, on the date stated above, at 12 N. p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S W Bowers, M. D.

19 (Address) 1617 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Sept 14 1923

20 UNDERTAKER J. C. Windfield

ADDRESS 914 Greenmount Ave

Cor.—1-12-23—M&T—100 Bks.

D79037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D79037

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Bond alley ST., 18 WARD)

2-FULL NAME Robt. O. Wilson

(a) RESIDENCE NO. 821 Bond alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Sigle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Robt Wilson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Sallie Brown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Robt Wilson
(Address) 821 Bond alley

15 Filed SEP 12 1923, 192 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT SPECIFIC NATURE OF DISEASE OR CONDITION should be stated. TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~(Inquest, autopsy or inquiry.)~~ his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Justs Enteritis

(duration) Life yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Food Poisoning

(duration) Life yrs. ..... mos. ..... ds.

(Signed) W R Powell (Coroner.), M. D.

9-11 1923 (Address) 111 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Cemetery

DATE OF BURIAL Sept 13, 1923

20 UNDERTAKER R. Lo. Gross.

ADDRESS 1403 McCulloh St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79038 40 D79038

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 23 WARD)

2-FULL NAME Mary Haskins

(a) RESIDENCE NO. 227 Henrietta ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Chesterfield Va.
(State or country)

PARENTS

10 NAME OF FATHER Anderson Haskins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not known.

12 MAIDEN NAME OF MOTHER Maria Hagerstown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known.

14 Informant Henry Haskins
(Address) Chesterfield Va.

15 Filed SEP 12 1923 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1923, to Sept. 10, 1923, that I last saw her alive on Sept. 10, 1923, and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:
Bilateral Salpingitis & Tubo ovarian abscess and pelvic adhesions

(duration) 17 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 5-1923

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mosby Junction, Va	Sept 14 1923
20 UNDERTAKER Chesterfield Va	ADDRESS
J. D. Brown & Son	108 W. Monty

by mail T.S. 0 R 2

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79039 51 D79039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 612 W. Lanvale St. WARD) 17

2-FULL NAME Irene Darnell

(a) RESIDENCE NO. 612 W. Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. 2 mos. 1 ds.

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonza P. Darnell

6 DATE OF BIRTH (month, day, and year) July 8, 1890

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
33	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer) 027
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. W. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hanna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maggie Armstrong
(Address) 612 W. Lanvale St.

15 Filed ....., 192 .....
SEP 12 1923 ROBERT R. KRAUTER
Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos 35 ds.

CONTRIBUTORY (Secondary) arthritis (Rheumatic)

(duration) yrs. 4 mos. ds.

(Signed) J. E. Hennessey, M. D. (Coroner.)

Sept. 10, 1923 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Sept 13 1923

20 UNDERTAKER Samuel Hanly ADDRESS 1900

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79040

CERTIFICATE OF DEATH. 113 D79040

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 535 Saulsbury Place ST., 13 WARD)

2-FULL NAME Edward Darin Harris

(a) RESIDENCE NO. 535 Saulsbury Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 13 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Infant)
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward D. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Frances Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant ..... Frances Harris
(Address) 535 Saulsbury Place.

15 Filed ..... , 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) 6 yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hemler, M. D.
(Coroner)

Sept. 11, 1923 (Address) 270 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Sept 15 23

20 UNDERTAKER David Hamsley

ADDRESS W. Balto

IN CASE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79041 90 D79041

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 N Montford ave ST., 8 WARD)

2-FULL NAME Laura E Tubman

(a) RESIDENCE NO. 1625 N Montford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theadore J Tubman

6 DATE OF BIRTH (month, day, and year) Jan 5th 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Mitchel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Theadore J Tubman (Address) 1626 N Montford ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1922 to Sept 10, 1923, that I last saw her alive on Sept 9, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation

myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Fell Maggioso, M. D.

9/11, 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 12, 1923
20 UNDERTAKER Robt J Turner Jr	ADDRESS 1442 N Broadway

N. B.—WRITE PLAINLY, mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79042

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D79042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1436 E Fort St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: ~~Margaret Delaney~~ Wagner

(a) Residence No. 1436 E Fort St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 11, 1923

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or. 3 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: William H. Wagner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Margaret Delaney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): William H Wagner
(Address): 1436 E Fort Ave

15- Filed SEP 12 1923 192.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 19 23 to Sept 11 19 23 that I last saw h[illegible] alive on Sept 11 19 23 and that death occurred, on the date stated above, at 1105 m.

The CAUSE OF DEATH* was as follows:

Intra-Uterine asphyxia

(Duration) 3 min. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. Fa Scarnes M. D

9/11/23 (Address) 2878 Hanford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 12 1923

20-UNDERTAKER: Robt S Turner & Son — ADDRESS 1442 N Broadway

should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

D79043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D79043

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute St. Joseph Hospital 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... George Spitznagle

(Residence in Baltimore: No. 2228 Eager Place St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	married

6-DATE OF BIRTH. Feb 22/1862 (Month) (Day) (Year)

7-AGE. 61 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Huckster
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Philip Spitznagle

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Figg

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Anna Spiyznagle

(Address)..... 2228 Eager Place

15-

Filed..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10/23 (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Indigestion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration).....yrs.....mos. 14 ds.

(Signed) S. S. Patterson M. D.

(Coroner.)

sept 11/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Sept 13th 1923
20-(N) UNDERTAKER. Philip Herwig	ADDRESS. 3816 Orleans St

N. B.—Every item of information should be carefully obtained and recorded so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms,

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79044

9K-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Shelter for Aged Colored Persons ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Lewis Harvey

(a) RESIDENCE. NO. Shelter for Aged Colored ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't Know

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mattie J. Sheller

(Address) 517 W. Biddle St.

15 Filed SEP 12 1923, 19.. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1923, to Sept. 10, 1923, that I last saw her alive on Sept. 9, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diffuse Arterio-Sclerosis

(duration yrs. 6 mos. ds.)

CONTRIBUTORY (Secondary) Pulmonary Edema (duration yrs. 1 mos. 14 ds.)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Examination

(Signed) W. F. Carr, Dr., M. D.

, 19 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Sept 12 1923

20 UNDERTAKER Chas. E. Franck

ADDRESS 501 Madison

nation should be carefully supplied. All blanks must be properly classified. Exact statement of DECEASED CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Walker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79045 47 D79045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 4606 1st Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Walker

(a) Residence No. 4606 1st Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced, HUSBAND of William John Walker

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 46 yrs. [illegible] mos. [illegible] ds. If LESS than 1 day, hrs. mn. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. James Barry

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Jane Johnson

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Baltimore

14- (Informant). John Walker

(Address) 4606 1st Ave & 12th

15- Filed [illegible] 19[illegible]. ROBERT N. KRAUTER, Registrar.

SEP 12 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 10-23

17- I HEREBY CERTIFY, That I attended deceased from August 1 1923, to Sept 10 1923, that I last saw h[illegible] alive on Sept 2 1923, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Heart Failure with Chronic Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L. Yahnton M.D.

1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel — DATE OF BURIAL. Sept 12 1923

20-UNDERTAKER. John W Henderson & Monument — ADDRESS 15 01

should be carefully supplied. Age should be given in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79046 129 D79046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 E Preston ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Rebecca Kepler

(a) RESIDENCE NO. 1416 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 8 - 1891

7 AGE

Years	Months	Days	If LESS than I day, hrs. or min.
32	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady.

(b) General nature of industry, business, or establishment in which employed (or employer): 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Geo W. Kepler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER Mary A Weisbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant Mr Mary A Kepler

(Address) 1416 E Preston

15 Filed . . 19 SEP 12 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1923, to Sept 10, 1923,

that I last saw living on Sept 9, 1923;

and that death occurred, on the date stated above, at 9 55 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. T. Sems, M. D.

(Address) 6111 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Sept 12 1923

20 UNDERTAKER: John Ellicott — ADDRESS: 2108 Eutaw

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be CAREFULLY GIVEN. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79047

CERTIFICATE OF DEATH.

145-003

REGISTERED NO. D79047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. (WARD)

2-FULL NAME Elva Henrietta Brown

(a) RESIDENCE NO. 657 Dover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Brown

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundle Co

PARENTS

10 NAME OF FATHER Richard Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundle Co

12 MAIDEN NAME OF MOTHER Elizabeth Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundle Co

14 Informant (Address) Father 222 Ostorlein St

15 Filed SEP 12 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 10, 1923, that I last saw her alive on Sept 10, 1923, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis from Ruptured Pregnant Uterus

(duration) about yrs. 21 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 10-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) R. B. Kyler M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marks Cem DATE OF BURIAL Sept 13 19 23

20 UNDERTAKER Daniel Easton ADDRESS 516 Dover St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of date of birth should be properly classified. Exact information should be given in answering all questions, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death should be given in answering all questions, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79048 X 100-001 D79048

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Eutaw ave. ST., 26 WARD)

2-FULL NAME Earl D. Kidwell.

(a) RESIDENCE NO. 4 Eutaw ave. ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12th 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. (Old)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va.

PARENTS

10 NAME OF FATHER Leslie E. Kidwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Editte V. Wigginton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Leslie E. Kidwell (Mother)
(Address) 4 Eutaw ave.

15 Filed ..... 19..... Registrar

SEP 12 1923 ROBERT R. KRAUTER, BURIAL PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923 to Sept 11, 1923 that I last saw h[illegible] alive on Sept 11, 1923, and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

B. Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav A. Hay, M. D.

19 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means nnd Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept. 12 1923
20 UNDERTAKER Lilly & Geiler	ADDRESS 4032 W. North Ave

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See Affadivover)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79049

CERTIFICATE OF DEATH.

12

D79049

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 646 Aull St ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mitchell

(a) RESIDENCE. No. 646 Aull ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 2 - 1871 Auburn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Mrs Hannah Mitchell (Address) 646 Aull St.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 10 - 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12th, 1923, to Sept 9th, 1923 that I last saw h.. alive on Sept 9th, 1923 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gastritis (duration) yrs. 4 mos. 21 ds.

18 Where was disease contracted if not at place of death? 646 Aull St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas C Capers, M. D.

. 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Sept. 12 1923

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1735 Hanford Ave.

ROBERT R. KRAUTER, Burial Permit Clerk

mation should be carefully supplied. Exact statements as to CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

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Personally appeared before me this 15th day
of October Mrs Mary. Mitchell wife of
William Mitchell who made affadavit that
the age given on Death Certificate #D.79049
is incorrect, the same should read..
born Sept 2nd 1871- 52 yrs + 8 days

her
Seal Mary X Mitchell Wife
mark

Seal George H Grese
Notary Public

alvular heart disease;
etc. The contributory
affection need not be
mple: *Measles* (disease
chopneumonia (second-
e symptoms or terminal
ia," "Anemia" (merely
ollapse," "Coma," "Con-
enital," "Senile," etc.),
eart failure," "Hemor-
us," "Old age," "Shock,"
when a definite disease
se. Always qualify all
birth or miscarriage, as
PUERPERAL *peritonitis*,"
surgical operation was
EATHS state MEANS OF
CIDENTAL, SUICIDAL, or
such, if impossible to
ples: *Accidental drown-*
in—accident; Revolver
oisoned by carbolic acid
ture of the injury, as
equences (e. g., *sepsis*,
r the head of "contribu-
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URTHER STATEMENTS
IAN.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79050

CERTIFICATE OF DEATH.

159-001

159 D79050

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 Poplar Grove Terrace St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jane Smyrke

(Residence in Baltimore: No. 2905 Poplar Grove Terrace St.; ....yrs., ...mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, September 6, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Mawson Smyrk

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Blanche Gideon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Mawson Smyrk

(Address) 2905 Poplar Terrace

15-

Filed....., 191....
Registrar.

P 21923 ROBERT R. KRAUTER Burial Permit Clerk

N.B.—Every item of information should be properly answered, so that it may be CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1923, to Sept 11 1923, that I saw her alive on Sept 11 1923, and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

Depression of Respiratory Centers

(Duration) 5 yrs. 5 mos. 3 ds.

CONTRIBUTORY (Secondary) Hydro-Cephaloid Left

(Duration) ....yrs. ....mos. ....ds.

(Signed) George C Shannon M. D.

Sept 12, 1923. (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Sept 12 1923

20-UNDERTAKER Wm J Pechuerlon — ADDRESS North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79051

D79051

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) Residence No. 608 N. Bethel st. St., Ward.....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1896

7-AGE.	If LESS than 1 day.
27 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Armistead Smith

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Rosa Foster

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Virginia

11- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 12 1923, 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 10, '23

17- I HEREBY CERTIFY, That I attended deceased from July 24 1923 to Sept. 10 1923

that I last saw h. im alive on Sept. 10 1923

and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous pneumonia

(Duration) 1 yrs. 16 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D

9-10-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Bush Cemetery	Sept. 12 1923
20-UNDERTAKER. Edward Burton	ADDRESS 1631 Orleans St

should be carefully supplied. Exact statement of ... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

D79052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79052

CERTIFICATE OF DEATH.

1923

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Hammond

(Residence in Baltimore: No. 1226 Short Alley St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	black	single

6-DATE OF BIRTH. unknown (Month) (Day) 1..... (Year)

7-AGE. 30 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: servant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). H

12-MAIDEN NAME OF MOTHER. H

13-BIRTHPLACE OF MOTHER. (State or Country). H

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elliott (Undertaker)

(Address) 1725 ashland ave

15-

Filed ..... 192.....

Registrar.

N. B.—Every item of information should be carefully considered, that it may be properly classified. Every state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said her (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage- Throat cut by John Jones col. alias "Hot Corn" at 4 N., Spring St.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Pattison M. D. (Coroner.)

9/12/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel	Sept 12 1923

20-UNDERTAKER.	ADDRESS
Mrs R. A. Elliott	1725 ashland ave

RECEIVED R. KRAUTER SEP 21 1923 Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

165-190

HEALTH DEPARTMENT—CITY OF BALTIMORE

X84 D79053

D79053

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ....., ST., ... WARD)

2-FULL NAME Emma Bartzis

(a) RESIDENCE No. 713 E. King St ST., ... WARD Martinsburg, W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bartzis

6 DATE OF BIRTH (month, day, and year): Nov. 18-1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wesley Ullem

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Dovenbarger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed SEP 12 1923 19..... ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 23, 19 23, to Sept 11, 19 23.

that I last saw her alive on Sept 11, 19 23

and that death occurred, on the date stated above, at 11 47 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Brain tumor (Endothelioma)

(duration) 6 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? ~~Home~~

Did an operation precede death? Yes Date of July 27, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? P. Exam

(Signed) W. H. McPherson M. D.

8/12/1923 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W Va — DATE OF BURIAL: Sept 12 1923

20 UNDERTAKER: Joseph Abrens — ADDRESS: 221 Bway

—WRITE plainly. Every question should be carefully answered. Any information should be carefully supplied. Any omission may be properly classified. Read CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Blouse.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79054 X 40 D79054

Registered No. .....

D79054

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Blouse

(a) Residence No. Gorsuch Road Walbrook Ward 2nd

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Blouse

6-DATE OF BIRTH (month, day and year) 1902

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?37

(b) General nature of Industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer Md.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Andrew Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Helena Hymans

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Hospital Record

(Address) .....

15- Filed ..... 192.. Registrar.

SEP 12 1923 ROBERT R. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9/12/23.

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 19.23 to Sept 12 19.23.

that I last saw her alive on Sept 12 19.23 a

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Otitis Media - Influenza

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) K. W. Bolby M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL. Sept 14, 1923

20-UNDERTAKER. Edmondson ADDRESS 3615 Gorsuch

EXACT statement of facts should be carefully supplied. All questions must be answered, and the cause of death properly classified. Examine the certificate carefully before signing it, and write in plain terms, so that it may be properly classified. Consult instructions on back of certificates.

...TIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably pneumonia

D79055

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D79055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2301 Belair Rd. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary ANN Lewis

(Residence in Baltimore: No. 3200 ~~Elmore~~ Elmley Ave. St., 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (write word.)
female	white	married

6-DATE OF BIRTH, December 19/1856
(Month) (Day) (Year)

7-AGE. 66 yrs. 9 mos. 9 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. David Finn

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Welsh

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M.J.Lewis (husband)

(Address) 3200 ~~Elmore~~ Elmley Ave

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

SEP 21 1923

N. B.—Every item of information should be properly answered, so that it may be plain terms, so that it state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma (Probably Caecum from History)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J.S.H. Patton M. D.
(Coroner.)

9/12/23 (Address) 1508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Cathedral Com	Sept 13th 1923
20-UNDERTAKER.	ADDRESS
J.A. Moran	3000 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Roscoe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79056

CERTIFICATE OF DEATH.

X 129 D79056

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913½ Gilmore St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Mathilda Roscoe

(a) RESIDENCE. No. 913½ Gilmore St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John T. Roscoe

6 DATE OF BIRTH (month, day, and year) April 23, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Concord North Carolina

PARENTS

10 NAME OF FATHER Julius Sherrin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Concord North Carolina

12 MAIDEN NAME OF MOTHER Ammanda (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Concord North Carolina

14 Informant John T. Roscoe
(Address) 913½ Gilmore St

15 Filed ....., 19..... Registrar

SEP 12 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 11, 1923, that I last saw her alive on Sept 10, 1923, and that death occurred, on the date stated above, at 6.35a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical signs & symptoms

(Signed) John G. Campbell, M. D.

9-12 1923 (Address) 1405 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Concord. N. C. — DATE OF BURIAL: Sept 12 1923

20 UNDERTAKER: Samuel W Casetta — ADDRESS: 1400 Mosher

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Interstitial
Nephritis

D79057

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D79057

CERTIFICATE OF DEATH.

11

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 925 Linden Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Nees St.; yrs., 11 mos. ..... ds.)

(Residence in Baltimore: No. 925 Linden Ave.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, about 1855
(Month) (Day) (Year)

7-AGE. 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tinner-Sheet Metal
(b) General nature of industry, business, or establishment in which employed (or employer): Worker Self

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Martin Nees

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Pegaud

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria Wewerka

(Address) 1118 N. Wolfe St.

15- SEP 13 1923 ROBERT R. KRAUTER, Registrar.

Filed ..... 192.

N. B.—Every item of information should be given if possible, so that it may be properly transcribed. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Name of informant is very important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) and Kidney

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

Sept. 11 1923 (Address) 2802 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Sept 13 1923
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 W. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79058 D79058 100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Little Wilson ST.: 16 WARD)

2-FULL NAME Austin Scott

(a) RESIDENCE. NO. 1104 Little Wilson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Parker

6 DATE OF BIRTH (month, day, and year) June 1-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Air Forge Co

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Charles Scott

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Va.

12 MAIDEN NAME OF MOTHER Katy Lewis

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Va.

14 Informant Fannie Scott (Address) 1104 Little Wilson St

15 Filed SEP 13 1923, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1923, to Sept 10, 1923, that I last saw h— alive on Sept 9, 1923, and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Carcinoma

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) K D K Emrich, M. D.

9/12, 1923 (Address) 1707 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 13 1923
20 UNDERTAKER	ADDRESS
C. N. Brown & Son	1818 Mary

mation should be carefully prepared, so that it may be properly classified. PARTICULAR attention should be given to the CAUSE OF DEATH in plain terms

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Sputum Negative

Spec.—1-10-21—M&T—1500 Bks.

D79059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79059

57

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 E. Barney ST., 14 WARD)

2-FULL NAME Pasquale Feduccia

(a) RESIDENCE NO. 105b E. Barney ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Concettina Marino

6 DATE OF BIRTH (month, day, and year) Mar 15-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs.	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

PARENTS

10 NAME OF FATHER Nicolo Feduccia

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Rosina Feduccia

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Concettina Marino (Address) 105 E. Barney St

15 Filed SEP 13 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923 to Sept 11, 1923

that I last saw him alive on Sept 11, 1923

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DeLauro M.D.

(Address) 407 N. Eutaw St

Sept 12, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 13th 1923

20 UNDERTAKER Geo. J. Ruth 1735 Harford ave.

ADDRESS

Burial Permit Clerk

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79060 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 45 D79060

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1921 E Federal ST., 8 WARD)

2-FULL NAME Calvin L. Kirby

(a) RESIDENCE No. 1921 E Federal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Grace R. Kirby

6 DATE OF BIRTH (month, day, and year) June 10 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	34	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Clarence A. Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sarah Foote

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Grace R. Kirby

(Address) 1921 E. Federal St

15 Filed SEP 13 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1923 to Sept 11 1923 that I last saw him alive on Sept 10 1923 and that death occurred, on the date stated above, at 8.05 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestines

(duration) yrs. 7 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 8-23 " 18-23 Mch 16-23

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Section

(Signed) E. Gill Ball, M. D.

Sept 11-1923 (Address) 1631 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept 14 1923

20 UNDERTAKER Henry Horck ADDRESS Lens 1201 E Eager St

mation should be carefully supplied. Each item may be properly classified. Read CAUSE OF DEATH in plain terms, so that it may be properly classified. Read TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79061

11-001 D79061

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Enson ST., 10 WARD)

2-FULL NAME James H Jones

(a) RESIDENCE NO. 111 Enson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. [redacted] mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dula Jones

6 DATE OF BIRTH (month, day, and year) Mar 11- 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not Home

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Not Home

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Home

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) North Carolina

14 Informant Dora Jones (Address) 111 Enson st

15 Filed SEP 13 1923 19 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-23 19

17 I HEREBY CERTIFY, That I attended deceased from 9-7-23, 19 23 to 9-11, 19 23 that I last saw him alive on 9-11, 19 23 and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following the Grippe (duration) yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Fred Bruckley M. D.

19 23 (Address) 1000 Hall Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Sept 14, 23

20 UNDERTAKER H. C. Miller — ADDRESS 2334 Jefferson St

mation should be carefully supplied. Name CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of death TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79062

HEALTH DEPARTMENT--CITY OF BALTIMORE

49

D79062

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Jefferson ST., 6 WARD)

2-FULL NAME Minnie Rohm

(a) RESIDENCE No. 2403 Jefferson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August H. Rohm

6 DATE OF BIRTH (month, day, and year) April 16 1882

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michalas Ackerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Josephine Junkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant August Rohm (Address) 2403 Jefferson

15 Filed ..., 19.. ..... Registrar

SEP 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to Sept 12, 1923, that I last saw h[illegible] alive on Sept 11, 1923, and that death occurred, on the date stated above, at 11:50 A.m.

The CAUSE OF DEATH* was as follows:

Lymphic Sarcoma of Superior Mediastinum + Pleurisy with effusion

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray Examination

(Signed) Albert L. Singewald M. D.

1923 (Address) 1613 E. Baltimore Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 15 1923

20 UNDERTAKER Jos. J. Herr

ADDRESS 156 N. Lanvale

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79063

CERTIFICATE OF DEATH. X 43

D79063

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Thomas

(a) RESIDENCE NO. Frostburg Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? 35 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~WIFE of~~) Alice Davis Thomas

6 DATE OF BIRTH (month, day, and year) Aug 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Carliss Mines

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER David Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary ~~Lewis~~ Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed SEP 13 1923, 19 ..... ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1923, to Sept 12, 1923, that I last saw him alive on Sept 12, 1923, and that death occurred, on the date stated above, at 9 35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma right maxilla and antrum

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Sept 11 '23

Was there an autopsy? Partial

What test confirmed diagnosis? Operation

(Signed) F. E. Rehfuss M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frostburg Md — DATE OF BURIAL: 9/13/23

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79064

D79064

188-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

2-FULL NAME Andrew Morrow

(a) RESIDENCE NO 1806 Barclay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bartender
(b) General nature of industry, business, or establishment in which employed (or employer) (M. Laughlin)
(c) Name of employer ~~Herself~~

9 BIRTHPLACE (city or town) Balto - Md
(State or country)

PARENTS

10 NAME OF FATHER W. J. Morrow

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Lackey

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant James Morrow
(Address) 1806 Barclay

15 Filed ..... 192 ..... Registrar

SEP 13 1923 ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion brain. while riding in auto - collided with Street car (duration) About 2 hours yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Kelley M. D.
(Coroner)
(Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) about 24 hrs in Balto

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Sept 14 1923

UNDERTAKER E. A. Friedgen ADDRESS 501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be understood. Information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79065

CERTIFICATE OF DEATH.

D79065

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Geo. W. Cosden

(a) RESIDENCE NO. Northeast, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elkton Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Ida Cosden de Socio
(Address) North East Md

15 Filed ..... 19 ..... Registrar

SEP 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1923, to Sept 12 1923,
that I last saw him alive on Sept 12th 1923,
and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach
Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 10

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. M. Polcroft, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark Del. DATE OF BURIAL 9-14-1923

20 UNDERTAKER Geo. E. Brand & Son Madison Ga ADDRESS

ROBERT N. GRAUTEN, Capital Permit Clerk

mation should be carefully supplied. Use ink and write plainly. Do not use pencil. Be sure that it may be properly classified. Exact information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information TION is very important. See instructions on back of certificates.

D79066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002

D79066

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1140 N. Calhoun St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Thomas

(Residence in Baltimore: No. 1140 N. Calhoun St. St.; yrs., mos. 1/2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, Sept. 11, 1923
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 12 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wm. Geo Thomas

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Marian Geo

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Geo

(Address) 1140 N. Calhoun St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration).....yrs.....mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Heuisler M. D.
(Coroner.)

Sept. 12, 1923 (Address) 20 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	9/14, 1923
20-UNDERTAKER W. J. Dennis	ADDRESS 303 Pennsylvania Ave.

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D79067

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 McCulloh ST., 14 WARD)

2-FULL NAME Marguitte Jenkins

(a) RESIDENCE NO. 1709 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	3	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Jenkins

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant (Address) Wm Jenkins 1709 McCulloh

15 Filed SEP 13 1923, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1923, to 9/11, 1923.

that I last saw h[illegible] alive on 9/11, 1923

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Ac Gastritis + Debility
(a 7 months child)
(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Premature Birth
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Wm Roberts, M. D.

9/12 1923 (Address) 2, 314 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9/13 1923
20 UNDERTAKER Frank T. Lewis	ADDRESS 1305 E Baltimore

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diarrhoea

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79068

HEALTH DEPARTMENT—CITY OF BALTIMORE

160

D79068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 E. Wesh ST.: 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wm Welsh

(a) RESIDENCE: No. 136 E. Wesh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16/23

7 AGE: Years — Months 1 — Days 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md (State or country) 1201 S. Charles St.

PARENTS

10 NAME OF FATHER Joseph T Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Margaret Curry

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Wm Welsh

(Address) 136 E. Wesh

15 Filed ..... 19..... Registrar

SEP 13 1923

ROBERT R. KRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from August 28th, 1923. to Sept 11, 1923.

that I last saw him alive on Sept 11, 1923.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Infantile Atrophy

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick, M. D.

19 (Address) 412 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetary — DATE OF BURIAL: Sept 13 1923

20 UNDERTAKER: Margaret E. Flynn — ADDRESS 1422 Light St

NOTE—Information should be carefully supplied. AGE should be correctly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79069

CERTIFICATE OF DEATH.

31 D79069

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chris Barger

(a) Residence No. 3805 Lombard st. E. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Berger

6-DATE OF BIRTH (month, day and year): 1881

7-AGE: 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Joseph Berger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Hummel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed SEP 13 1923 ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 12, '23

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1923 to Sept. 12 1923

that I last saw him alive on Sept. 12 1923,

and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Otis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. A. Lally, M. D

9-12-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Sept 12 1923

20-UNDERTAKER: Philip Herwig — ADDRESS: 1816 Orleans A

Around the corners, so that it may be properly classified. Follow instructions in plain terms, so that it may be properly classified. Follow instructions on back of certificates.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc. *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably
Pulmonary Tuberculosis
Tubular Pneumonia
Arteriosclerosis
Chr. Nephritis
Fatty Liver
Pleural Adhesions

See Letter on File - M.I. Dr. late consult

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79070 — X-1-001 D79070

CERTIFICATE OF DEATH.

D79070

REGISTERED NO. .....

1-PLACE OF DEATH Woman's Hospital Room 126.

CITY OF BALTIMORE: (No. ..... ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs ~~Harry Bowman~~ Catherine Bruce Baetjer.

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Garrison, Maryland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry N. Baetjer

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	1	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edwin B. Bruce

11 BIRTHPLACE OF FATHER (city or town) Boston (State or country) Mass.

12 MAIDEN NAME OF MOTHER Eliz. Coale

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr Harry N. Bruce (Address) Garrison Md.

15 Filed SEP 13 1923 19 ... Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17 I HEREBY CERTIFY, That I attended deceased from August 23, 1923, to Sept 13, 1923,

that I last saw her alive on Sept 13th, 1923,

and that death occurred, on the date stated above, at 7.35 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Positive Widal & Clinical course

(Signed) Sydney R. Miller, M. D.

, 19 (Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Sept 14 1923

20 UNDERTAKER Henry N. Jenkins Est. Co — ADDRESS Richard & Eager

mation should be correctly supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79071

CERTIFICATE OF DEATH.

75-002 D79071

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2602 Mc Elderry ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Miller

(a) RESIDENCE NO. 2602 Mc Elderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Miller

6 DATE OF BIRTH (month, day, and year) Aug 31-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	82	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B. & O. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Katharina Loos

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant (Address) Miss Katie Wolf 2602 Mc Elderry St.

15 Filed SEP 13 1923 , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to Sept 11, 1923.

that I last saw him alive on Sept 10, 1923.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Senile

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alg A Bagl, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Co.

DATE OF BURIAL 9/14 1923

20 UNDERTAKER L. Lee McCarthy

ADDRESS 130 E. Fort

SEP 13 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

mation should be entered, etc., so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

14262 D79071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 159-001 D79072

REGISTERED NO. .....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1 ST., 9 WARD)

2-FULL NAME Foster Williams Jr.

(a) RESIDENCE NO. Smoke Run, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Foster Williams (Father)

6 DATE OF BIRTH (month, day, and year): March 3, 1922

7 AGE: Years ..... Months 6 Days 10 If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Foster Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: JOHNS HOPKINS HOSPITAL. Record
(Address)

15 Filed ..... 19 ..... ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1923. 19 . to Sept 13 1923. 19 .
that I last saw him alive on Sept 13, 1923. 19 .
and that death occurred, on the date stated above, at 5:25 p.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary): None
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Penna

Did an operation precede death? Yes Date of Sept 12, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? P & E

(Signed) Warfield M Frost M. D.

9/13, 1923 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rainey Pa

DATE OF BURIAL: Sept 13 19 27

20 UNDERTAKER: Joseph Arcieri

ADDRESS: 221 Run

Information should be carefully supplied, so that it may be properly classified. Use only standard terms. See list of CAUSE OF DEATH in plain terms, so that it may be properly classified. Use only standard terms. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

D79073

HEALTH DEPARTMENT—CITY OF BALTIMORE

86 D79073

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 15 WARD)

2-FULL NAME Henry J. Beck JR

(a) RESIDENCE NO. 1934 Clifton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chicken Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 1943
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henry Beck

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Maryland

13 BIRTHPLACE OF MOTHER (city or town) Phila Pa
(State or country)

14 Informant Henry Beck Sr
(Address) 1934 Clifton ave

15 Filed SEP 13 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 12, 1923, that I last saw him alive on Sept 12, 1923, and that death occurred, on the date stated above, at 6.30 PM.

The CAUSE OF DEATH* was as follows:

Chronic Suppurative Otitis Media with exacerbation
D. Acute Suppurative Mastoiditis
(duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral abscess
(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/6 - 9/9/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Thornwood Wilson M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept 16 1923

20 UNDERTAKER Lahrens & Co — ADDRESS 1611 Mad ave

NOTE—Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79074

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 O'Donnell St. ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry G. Fegelein

(a) RESIDENCE. NO. 2708 O'Donnell St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fegelein.

6 DATE OF BIRTH (month, day, and year) Nov. 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Fegelein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry Fegelein. 2919 Dillon St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 31st, 1923, to Sept. 11th, 1923, that I last saw h-im alive on Sept 11th. 1923, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. D. Wright, M. D.

9/13/1923 (Address) 1014 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Sept 14 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Now Fu

mation should be written in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79075 ✓ D79075

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette & Payson ST., 70 WARD)

2-FULL NAME Mrs. Winifred C. Busch

(a) RESIDENCE NO. 2502 N. Henry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Busch.

6 DATE OF BIRTH (month, day, and year): Nov 13 1865

7 AGE: 57 Years | Months | Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thomas Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. William Busch.

(Address) 2502 McHenry St

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

SEP 13, 1923

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Sept 12, 1923.

that I last saw her alive on Sept. 12, 1923.

and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 12 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical Data

(Signed) Hugh Donnell, M. D.

9/13/1923 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 9-15 1923

20 UNDERTAKER: E & B Hart 115

ADDRESS: E West St.

Spec.—1-10-21—M&T—1500 Bks.

079076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 114 ✓ 079076

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE. (No.) Or Lombard & Green ST.,S 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Ashton Lett.

(a) RESIDENCE NO. 2124 Oak ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (CAD)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cradock.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Preston Lett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Virginia Bovie.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant Hospital Record.
(Address)

15 Filed ..... 19 ..... Registrar

SEP 13 1923 ROBERT R. KRAUS Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Sept 11 1923, that I last saw h alive on Sept 11 1923, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intestional Intoxication

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 11, 1923

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) R. B. Peyton, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Sept 13 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 153 W Lombard St

N. B. mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D79077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79077

OK ✓ MK Gonda

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Deible

(a) RESIDENCE NO. Oella, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Charles Deible

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Fred Home

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Libby Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Chas. Deible
(Address): Oella, Md.

15 Filed. SEP 13 1923, 19 ..... ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 13, 1923, that I last saw her alive on Sept 13, 1923, and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH was as follows:

Acute Purulent Peritonitis following attempted abortion (self-inflicted)
Metritis - Salpingitis - Oöphoritis (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Scarlet Fever
(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) J. T. T. Stubbs, Jr., M. D.

9/13, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 14 1923

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79078

CERTIFICATE OF DEATH.

114 D79078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund . Mazan

(a) RESIDENCE NO. 519 s. Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph. Mazan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Pasek

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr Joseph . Mazan
(Address) 519 S. Washington St.

15 Filed ..... 19..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

SEP 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1923, to Sept. 12, 1923, that I last saw him alive on Sept. 12, 1923, and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Incidental Dysp.

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) Andrew Kwiatkowski, M. D.

, 19 (Address) 3529 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sk

DATE OF BURIAL 14 1923

20 UNDERTAKER John m Weber

ADDRESS 1893 Bank St

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

D79079 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D79079

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 925 E. Biddle ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph B. Finan

(Residence in Baltimore: No. 925 E. Biddle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED~~, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Mar. 31, 1865 (Month) (Day) (Year)

7-AGE, 58 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bernard Finan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Finan

(Address) 925 E. Biddle

15- SEP 13 1923 Robert F. Harrison, Registrar.

Filed ..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1923, to Sept 12 1923, that I saw him alive on Sept 12 1923, and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ? yrs. mos. ds.

(Signed) Lyman S. Abbott M. D.

9/13, 1923 (Address) 1832 N. Carlton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Sept 15, 1923

20-UNDERTAKER H. C. Wickfield ADDRESS 914 Fremont Ave

N. B. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D79080

D79080

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Garrett

(a) RESIDENCE NO. 907 N. Vincent St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Diver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Allen Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Henrietta Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Municipal Hospital Records

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10, 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 21, 19 23 to Sept 10, 19 23,

that I last saw him alive on September 9, 19 23,

and that death occurred, on the date stated above, at 3:15 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease; Myocarditis

(duration) ... yrs. 6 mos 10 ds.

CONTRIBUTORY (Secondary) Syphilis (duration) Unknown mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Reaction

(Signed) Claude T. Nance, M. D.

9/13/23 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

281

UNIVERSITY OF MARYLAND SEP 13 1923

Spec.—1-10-21—M&T—1500 Bks.

166198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79081

REGISTERED NO. D79081

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. " " " ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mell

(a) RESIDENCE NO. Bengies, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Not a resident yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced ~~HUSBAND~~ ~~or WIFE~~ of Harry & Katherine Mell Parents

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Maryland.

PARENTS

10 NAME OF FATHER Harry Mell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Katherine Carper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL Warder

15 Filed , 19 Registrar

P13 1923 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 , 1923 , to Sept 12 , 1923 , that I last saw her alive on Sept 12, 1923, and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Kidney

(duration) yrs. mos 1 week ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Sept. 10

Was there an autopsy? Yes. Operation

What test confirmed diagnosis?

(Signed) H. N. Meech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Sept 14 1923

20 UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fullerton

mation should be careful... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79082 HEALTH DEPARTMENT—CITY OF BALTIMORE 3/ D79082

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Kenwood Ave ST., 7 WARD)

2-FULL NAME Joseph Demus Brown

(a) RESIDENCE No 517 N. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula C. Brown

6 DATE OF BIRTH (month, day, and year) Oct 31/1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Lighting Super-

(b) General nature of industry, business, or establishment in which employed (or employer) visor B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Steelton, Pa.

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) Trenton (State or country) N.J.

12 MAIDEN NAME OF MOTHER Julia Wheat

13 BIRTHPLACE OF MOTHER (city or town) N.Y. (State or country)

14 Informant Lula C. Brown

(Address) 517 N. Kenwood Ave

15 Filed SEP 13 1923, 192 Robert P. Harrison, Registrar

TION is very important. See instructions on

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

Also Dementia Paralytica

(duration) 5 or 6 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Bates, M. D. (Coroner.)

9/13/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Gen

DATE OF BURIAL Sept 16 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79083

CERTIFICATE OF DEATH.

D79083

60-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Hebrew Hosp ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bertha Glass.

(a) RESIDENCE. No. 1723 Pennsylvania ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
18	1	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Glass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Klamansky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Chas Glass
(Address) 1723 Penna ave

15 Filed SEP 14 1923, 19 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 13, 1923, that I last saw her alive on Sept 13, 1923, and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure — (during operation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hyperthyroidism

(duration) yrs. mos. 4 Wks.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 13, 1923

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Howard M. Kerr M. D.

9/13, 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	9/14 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. THIS IS very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exoptatum Jodi-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

131

D79084

CERTIFICATE OF DEATH.

REGISTERED NO. D79084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard L. Kruger

(a) RESIDENCE. NO. 1314 W. Northwest ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White-Jewish	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Louis 1439 Fisher St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/23

17 I HEREBY CERTIFY, That I attended deceased from Aug-24 . 1923. to Sept. 13. 1923 that I last saw h[illegible] alive on Sept. 13 . 1923, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

3 days. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy & acute retention. Pyelonephritis → myocarditis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 9/9/23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidore I. Fry, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehren Keseny Rm

DATE OF BURIAL 9/14 19 23

ADDRESS

20 UNDERTAKER Jack Louis 1439 Fisher St

SEP 14 1923 ROBERT R. PRICE REGISTRAR

Information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 1-10-21 M&T 1500 Blks.

166200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79085

CERTIFICATE OF DEATH.

X 16-002

D79085

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " " ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Robinson.

(a) RESIDENCE NO. 221 Camel St. City ST., WARD 6.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ ~~(or) WIFE~~ of

6 DATE OF BIRTH (month, day, and year): March 16, 1923

7 AGE: Years —; Months 5; Days 27.

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. NO

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cuba

PARENTS

10 NAME OF FATHER: Henry Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Sallie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Record JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept 12, 1923, that I last saw her alive on Sept 12, 1923, and that death occurred, on the date stated above, at 9.25 A.m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bunn M. D.

9/13, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL 9/14/23

UNDERTAKER: Jas. H. Gusley ADDRESS 178 N Bond

mation should be careful
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79086

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D79086

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 May ST., 5 WARD)

2-FULL NAME Ruby V. Payne

(a) RESIDENCE No. 1314 May ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10-1923

7 AGE — Years: — Months: 3 Days: 2 If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Ernest Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Charity Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Charity Payne
(Address) 1314 May St

15 Filed SEP 14 1923, 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 12, 1923, that I last saw h[illegible] alive on Sept 11, 1923, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo J Martin M. D.

, 19.. (Address) 2246 39th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Sept 14 19..

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans

information should be [illegible] CAUSE OF DEATH in plain terms, so that it may be properly [illegible] TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Bks.

D5120 D74087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74087

CERTIFICATE OF DEATH.

58-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 10 WARD)

2-FULL NAME Mrs. Pauline Walter (Jan Horn)

(a) RESIDENCE No. 1002 Willingers Court E. City. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Mrs. J. Johnson, sister) 2118 S. Charles St. City

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1866.

7 AGE: Years 54. Months 11. Days 10. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ... (State or country) Germany

PARENTS

10 NAME OF FATHER Edward.

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Fozan.

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Germany

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

SEP 14 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Sept 13, 1923, that I last saw her alive on Sept 13, 1923, and that death occurred, on the date stated above, at 10 10 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

* (duration) 8 yrs. + mos + ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) T. R. Harmon, M. D.

9/13, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Mathews | DATE OF BURIAL: Sept 10 1923

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E North Ave

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Grady 4218 Harford Road.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79088

CERTIFICATE OF DEATH.

113 D79088

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 832 Hillen St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane E Robertson

(a) Residence No. 832 Hillen St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 5 1923

7-AGE: yrs. 5 mos. 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS.

10-NAME OF FATHER: James Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Annie Myers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant) Mrs Jane Robertson

(Address) 832 Hillen St

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 13 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 28th 1923, to Sept 13th 1923, that I last saw him alive on Sept 12th 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma - Eruleus

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Diagnosis

(Signed) L. L. Grady, M. D.

9-13, 1923 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL, Sept 14 1923

20-UNDERTAKER: J. M. Work ADDRESS 551 E Lafayette

Please write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79089

CERTIFICATE OF DEATH.

24-001

D79089

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Elizabeth Sane ST., 23 WARD)

2-FULL NAME Adolph. Jurgens.

(a) RESIDENCE NO. 1625 Elizabeth Sane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Jurgens

6 DATE OF BIRTH (month, day, and year) Apr 3, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	67	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) o/o

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Meyerly
(Address) 491 Eveleigh

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 - , 1923, to Sept. 12, 1923, that I last saw him alive on Sept. 11, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Artero-Sclerosis

(duration) 3. yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorhage.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hess. M. D.

9-12 1923, (Address) 5600. York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 9/15 1923

20 UNDERTAKER J. Frew Mitchell

ADDRESS 130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

D79090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79090

1-PLACE OF DEATH

City of BALTIMORE: (No. Ft. Mg Hospital St., 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nida Spriggs

(Residence in Baltimore: No. 3 C Dennis Md, St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. July (Month) 2 (Day) 1925 (Year)

7-AGE. 8 yrs. 1 mos. 11 ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. Marion Spriggs

11-BIRTHPLACE OF FATHER. (State or Country) Md

12-MAIDEN NAME OF MOTHER. Francis Jones

13-BIRTHPLACE OF MOTHER. (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Spriggs

(Address) 3 C Dennis Md

15-

Filed..... 192.....

ROBERT R. KRAUTER
Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 12 (Month) (Day) 1933 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acid Burns 2nd Deg.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Forgeard

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Black M. D.
(Coroner.)

Sept 12 1933 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Ridgeley	Sept 13 1933
20-UNDERTAKER. Geo T Gibson	ADDRESS 613 Fawn

state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. This is very important.

Cor.—I-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79091

188-003 D79091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hos (St.) 4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Mittendorff

(a) RESIDENCE NO. Arlois Hotel (St.) Pratt St (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louisa Mittendorff

6 DATE OF BIRTH (month, day, and year) Feb 18, 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69 Yrs.	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ret. Lieut
(b) General nature of industry, business, or establishment in which employed (or employer) Navy U.S.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER C. C. Mittendorff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Aletta Hohmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Jno Mittendorf
(Address) 1648 Chilton St

15 Filed ....., 192 .....
Registrar

ROBERT R. KRAUTER
SEP 14 1923
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Femur Lac & Shock
after auto accident. Fract. Femur
acc. Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion
(Duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Sept. 14 1923 (Address) 1451 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., Grn mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept 16 1923

20 UNDERTAKER: Geo W Little — ADDRESS: 2700

(1) HON is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D79092

HEALTH DEPARTMENT—CITY OF BALTIMORE

112 D79092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 Kelly place St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Martin

(a) RESIDENCE NO. 235 Kelly place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Martin

6 DATE OF BIRTH (month, day, and year): March 1/1853.

7 AGE: Years 70. Months 6. Days 11. If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Rachel Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mrs Florence Shaffer (Address) 235 Kelly place.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1923, to Sept 12 1923, that I last saw h— alive on Sept 11 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms —

(Signed) C B Norment M. D.

9.13. 1923 (Address) 3542 Chelsea Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem Hampden

DATE OF BURIAL: 9/15 1923.

20 UNDERTAKER: J Walter Davis Jr.

ADDRESS: 3307 Paine St

mation should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SEP 14 1923 ROBERT N. KRAUTER, Burial Permit Clerk

SEP 15 1923 Burial Permit Clerk

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79093

CERTIFICATE OF DEATH.

90 D79093

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 727 E. Preston St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret E. Wards

(a) Residence No. 727 E. Preston St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of No

6-DATE OF BIRTH (month, day and year) Mar 16, 1869

7-AGE. 54 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer). at Home 064

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Ward

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Julia Linnal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. [illegible]

(Address) 727 E. Preston

15- Filed..... 192.....

SEP 14 1923 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1923 to Sept. 12, 1923 that I last saw her alive on Sept. 12, 1923 and that death occurred, on the date stated above, at 11:50 p.m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Mary F Voeglem, M. D.

Sept 13 1923 (Address) 1028 Voeglem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Cathedral Cem. DATE OF BURIAL, Sept 15 23

20-UNDERTAKER. Edward W. Conklin ADDRESS 1247 E. Eager St

in plain terms, so that it may be properly examined instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79094 D79094

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 E Federal ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Wittgrefe

(a) RESIDENCE NO. 1721 E Federal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Wittgrefe

6 DATE OF BIRTH (month, day, and year) Mar 31—1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Strauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hutter

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Conrad Wittgrefe

(Address) 1721 E Federal

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17 I HEREBY ~~CERTIFY~~, That I attended deceased from June 14, 1923, to Sept 13, 1923, that I last saw h~~e~~ alive on ~~Sept~~. 13, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ... yrs. 1½ mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? E. S. Hurd

(Signed) ..... M. D.

9 13 1923 (Address) 801 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 15 1923

20 UNDERTAKER John Elliott

ADDRESS 2008 Eutaw

ROBERT N. KRAUTER

SEP 15 1923

Burial Permit

mation should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79095

CERTIFICATE OF DEATH.

162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pratt

(a) RESIDENCE NO. 1536 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Edward Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Anna Lillian Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital.

15 Filed SEP 14 1923 19 ROBERT H. KRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923. to Sept 11, 1923. that I last saw h alive on Sept 11, 1923, and that death occurred, on the date stated above, at 7 00 a.m.

The CAUSE OF DEATH* was as follows:

Fetal atelectasis asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C E Duncan, M. D.

9/11, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Sept 13 1923

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Deputy Commissioner Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D79096

Spec.—1-10-21—M&T—1500 Bks.

Marcos Reyes

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X-31 D79096

1-PLACE OF DEATH U.S Marine Hospital, Baltimore Md

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. U.S Marine Hospital ST., 12 WARD)

2-FULL NAME Marcos Reyes

(a) RESIDENCE NO. U.S. Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. 6 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Trader.

(c) Name of employer S. Montpelier Co. Robt Ramsey & Co. City

9 BIRTHPLACE (city or town) (State or country) Tampico, Mexico

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Robert Garcia Mexican Consul (Address) 816 Park Ave City

15 Filed SEP 14 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to Sept 12, 1923, that I last saw him alive on Sept. 12, 1923, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum

(Signed) C. J. McDevitt. M. D.

9/14 1923 (Address) U.S. Marine Hospt #1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Trinity Cemetery

DATE OF BURIAL 9/14 1923

20 UNDERTAKER J. Lucinson & Bro

ADDRESS 1127 E. Balto

mation should be written in plain terms, so that it may be properly c... CAUSE OF DEATH in plain terms, so that it may be properly c... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

079097 113 D79097

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 N. Duncan ST., 8 WARD)

2-FULL NAME Pauline M. Mc Elroy.

(a) RESIDENCE NO. 1826 N. Duncan ST., 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. nil

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter J. Mc Elroy.

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Pauline M. Patterson

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Peter J. Mc Elroy.
(Address) 1826 N. Duncan St.

15 Filed .....19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1923, to September 12, 1923, that I last saw h[illegible] alive on September 11, 1923, and that death occurred, on the date stated above, at. 11 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. 1 mos 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Albert Abrahams M. D.

1923 (Address) 2027 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept. 14th 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe St

ROBERT R. KRAUTER, Burial Permit Clerk

SEP 14 1923

mation should be written in ink and in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79098

101-001

D79098

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Bank ST., 7 WARD)

2-FULL NAME Michael J. Cohen.

(a) RESIDENCE NO. 2000 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katharine Cohen.

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener at [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Patterson Park.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER David Cohen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katharine Cohen.
(Address) 2000 Bank St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1923, to Sept 13, 1923, that I last saw him alive on Sept 13, 1923, and that death occurred, on the date stated above, at 11 00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo. Heller, M. D.

9/14, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Sept. 17th 1923

20 UNDERTAKER Lilly & Sons

ADDRESS 4030 Wolfe St

mation should be properly classified, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79099 38 ✓ D79099

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Brice ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Henry Ebaugh.

(Residence in Baltimore: No. 821 Brice St.; ~~1~~ last of life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 27 (Day) 1855 (Year)

7-AGE, 68 yrs. 2 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoe cutter
(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturer

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Ebaugh

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rachel Bowman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Ebaugh

(Address) 821 Brice St

15-

Filed ....., 191.... Registrar.

SEP 14 1923 ROBERT R. KRAUTER
Burial Permit Clerk

CAUSE OF DEATH to be filled in plain words. Every question must be answered if certificate is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febry 1 1923, to Sept 13 1923, that I saw h[illegible] alive on Sept 12 1923, and that death occurred, on the date stated above, at 3.30a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Cor.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Locomotor ataxia

(Duration) 30 yrs. mos. ds.

(Signed) George C. Shannon M. D.

9/13, 1923 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery DATE OF BURIAL, Sept 15, 1923.

20-UNDERTAKER Josiah Lyser ADDRESS 1600 W North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79100 ✓ 44 D79100

D79100 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 Lemmora Ave 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Selma M Buchheimer

(a) Residence No. 118 Lemmora Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5yrs ds. How long in U. S., if of foreign birth? yrs. mos. d.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Buchheimer

6-DATE OF BIRTH (month, day and year) Nov 11 1837

7-AGE, 71 yrs. 10 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nothing

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town), (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Alex Mikowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Julia Graban

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Chas W Wolf

(Address) 118 Lemmora Ave

15- Filed....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Sept 13 1923 that I last saw h.. alive on Sept 13 1923 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Hubbard Trapp M. D.

(Address) 1407 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL, Sept 16, 1923

20-UNDERTAKER. Irwin Dyer

ADDRESS 1600 W North Ave

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

079101 — 185 079101

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Presbury ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henson Randolph

(a) RESIDENCE NO. 1613 Presbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edmonia Randolph

6 DATE OF BIRTH (month, day, and year) Feb. — 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Washington Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie Randolph

(Address) 1613 Presbury St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1923, to Sept. 11, 1923, that I last saw him alive on Sept. 11, 1923, and that death occurred, on the date stated above, at 9-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Fell from scaffold

(duration) — yrs. 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? Fell while drunk

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Wm. C. McCarthy M. D.

19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9/14 1923

20 UNDERTAKER J. W. Lewis

ADDRESS 1303 Pennsylvania Ave

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

SEP 14 1923 Robert P. Garrison, Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidents

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79102

D79102

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 416 (St.) Patapsco Ave. (WARD) 25

2-FULL NAME Eva A. Helmstetter

(a) RESIDENCE NO. 416 (St.) Patapsco Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of William Helmstetter

6 DATE OF BIRTH (month, day, and year) — 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Helmstetter (Address) 416 Patapsco Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1923, to Sept. 13, 1923.

that I last saw her alive on Sept 13, 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N.D. Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William H. Scott, M. D.

Sept 14, 1923 (Address) 816 Fleming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 9/17 1923

20 UNDERTAKER John F. Kelly & Sons

ADDRESS 1318 Light St

Sep 14 1923 Robert F. Harrison, Burial Permit Clerk.

mation should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79103 D79103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH St. Elizabeths Home Chestnut Heights

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elizabeth Myers.

(a) RESIDENCE. NO. Cor St. Elizabeths Home Chestnut Heights ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE negro

5 Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 9/23

7 AGE — Years ..... Months 6 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Garrison Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Alice Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 19

17 I HEREBY CERTIFY, That I attended deceased from August , 1923, to September 12, 1923, that I last saw h ee alive on September 12 , 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd , M. D.

Sept 14 1923 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important.

14923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79104 D79104 114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 E 22nd. ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johan Richard albert

(a) RESIDENCE NO. 525 E 22nd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 5, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph E Albert

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md —

12 MAIDEN NAME OF MOTHER Regina L Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md —

14 Informant Joseph E. albert
(Address) 525 E 22nd St.

15 Filed ..... , 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Sept 13, 1923, that I last saw him alive on Sept 13, 1923 and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Entritis

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Mongolism

(duration) 2 yrs. 7 mos. 8 ds.

18 Where was disease contracted if not at place of death? Hagerstown, Md —

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical —

(Signed) John S. Fraley, M. D.

9/14, 1923 (Address) 352 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept. 16 1923
20 UNDERTAKER	ADDRESS
E A Windfield	501 E 22

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

SEP 4 1923 Robert P. Garrison, Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79105

CERTIFICATE OF DEATH.

31

D79105

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1338 Argyle Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Floyd

(a) RESIDENCE. NO. 1338 Argyle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Floyd

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Loading ships

(c) Name of employer M. Johnson

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Md

PARENTS

10 NAME OF FATHER Henry Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne Co Md

12 MAIDEN NAME OF MOTHER Lizzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne Co Md

14 Informant (Address) James T Collins 1338 Argyle Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-10, 1923, to 9-11, 1923, that I last saw him alive on 9-11, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis NWN

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pneumonia Bilat

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William A Harris, M. D.

, 19 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Graceville Md — DATE OF BURIAL: Nov 15-1923

20 UNDERTAKER: Wm Roter - A Elliott — ADDRESS: 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

FEB 14 1923

Robert Harrison, Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e.g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79106

CERTIFICATE OF DEATH. 5

90 D79106

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 Forest St., 5 WARD)

2-FULL NAME Lev E. Lee

(a) RESIDENCE NO 306 Forest ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Lee

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ~~Worker~~ Packer of Cans 1886
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Dennis Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Maryan Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rochester Co. N.Y.

14 Informant Mrs. H. F. Elliott
(Address) 1723 Oakland Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
Sclr. Dis. Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Addict

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

Sept 14, 1923 (Address) 16 S. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 15, 1923
20 UNDERTAKER Mrs. Robert F. Elliott	ADDRESS 1723 Oakland Ave

TION is very important. See instructions on back of

SEP 14 1923 Robert F. Harrison, Chief Clerk.

Spec.—6-9-19—H.-P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79107 — 32 — D79107

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: No. 1704 N. Port St.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Buhl

(a) RESIDENCE. No. 1704 N Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1903

7 AGE — Years: 20 Yrs — Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Errand Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Howard Buhl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Barbara Sachs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Howard Buhl
(Address): 1704 N. Port St

15 Filed . 19 Robert P. Harrison Registrar

EP 141923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 23 to Sept 17, 19 23

that I last saw h[illegible] alive on Sept 12, 19 23

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

TB Meningitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) B O'Kelly, M. D.

. 19 (Address) 100 N Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 18 19 23
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79108 D79108

CERTIFICATE OF DEATH.

112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1132 Shields alley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Bailey

(a) RESIDENCE. NO. 1132 Shields alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1824

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	99	1824		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work for

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Daniel Easton

(Address) 916 Dr ave

15 Filed , 19 . Registrar

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/11 1923, to 9-12 1923, that I last saw h[illegible] alive on 9-12 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1132 Shields alley

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm R. Boyle, M. D.

, 19 (Address) 1618 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	9-15 1923
20 UNDERTAKER: Daniel Easton	ADDRESS 916 Dr ave

D 41923

Burial Permit Clerk.

Stock—12-23-21—E.B.R.S.—400 Blks.

D79109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Richard Hargrove

(a) Residence No. 116 S Stockton St., Ward Iron Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1902

7-AGE. 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Odd

(b) General nature of Industry, business, or establishment in which employed (or employer). Laborer

(c) Name of employer.

9-BIRTHPLACE (city or town) Va (State or Country),

PARENTS.

10-NAME OF FATHER, Wm. Hargrove

11-BIRTHPLACE OF FATHER (city or town) Va (State or Country),

12-MAIDEN NAME OF MOTHER, Carrie Branch

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Hospital Record

(Address)

15- Filed, ... 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/13/23

17- I HEREBY CERTIFY, That I attended deceased from 9/5/23, 19.. to 9/13/23, 19..

that I last saw him alive on 9/13/23, 19..

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever,

(Duration) ... yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Hemorrhage Cerebral from

(Duration) ... yrs. mos. ? ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Iron Va

DATE OF BURIAL, 9-15-1923

20-UNDERTAKER. Daniel Easton

ADDRESS 916 Eutaw

In plain terms, so that it may be properly ... instructions on back of certificates.

E 41923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79110 D79110

CERTIFICATE OF DEATH.

33

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor Lombard & Greene ST. S. 1 WARD)

2-FULL NAME Mrs Mary Lewis

(a) RESIDENCE NO. 706 ½ W. Saratoga STS. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, (Married), Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin Lewis

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
24 yrs.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER James A. Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records. (Address)

15 Filed . 19 Registrar

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 12, 1923; that I last saw her alive on Sept 12, 1923, and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos 5 days

CONTRIBUTORY (Secondary) Plastic Tuberculous peritonitis (duration) yrs. mos. Not Known ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? yes Date of Sept 12, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. A. Ryder, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft Lotus Cem

DATE OF BURIAL: 9-15 1923

20 UNDERTAKER: Daniel Ford

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79111 D79111

HEALTH DEPARTMENT—CITY OF BALTIMORE

48

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3510 E. Baltimore St. ST.: 46 WARD)

2-FULL NAME Catherine T. Osterhaus

(a) RESIDENCE. NO. 3510 E. Baltimore St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Osterhaus.

6 DATE OF BIRTH (month, day, and year) Nov. 16 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Theodore Busch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Hemkell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret. Osterhaus.

(Address) 3510 E. Baltimore St.

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1/23 1923, to Sept 17 1923, that I last saw h[illegible] alive on Sept 17 1923, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Tumor ?

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Epithelioma of face. Necrosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) W. Schaffer M.D.

(Address) 3307 E. Baltimore St. 9/13 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom Cem	Sept. 15 1923
20 UNDERTAKER Levy & Feiler	ADDRESS 2035 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be classified. TION is very important. See instructions on back of certificates.

P 41923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79112

CERTIFICATE OF DEATH.

74-00 D79112

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Lamont Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kucera (Kutcher)

(Residence in Baltimore: No. 1029 Lamont Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Sept Known, 1 (Month) (Day) (Year)

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Kucera

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Kutcher

(Address) 816 N. Durham st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191, to ....., 191; that I saw h alive on ....., 191, and that death occurred, on the date stated above, at 10-30 P.m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Sept 15, 1923

20-UNDERTAKER Frank Gracheln

ADDRESS Woodlawn

CAUSE OF DEATH must be plainly written. Every question must be answered. Physician's address must be given. Undertaker's name must be given. Please read carefully. Every item important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79113

CERTIFICATE OF DEATH.

119 D79113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Julia Jennings

(a) RESIDENCE NO. 614 N. Mount St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	black	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	8	15	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs J. N Waller, 115 Carlton Rd

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Burley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Burley

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 13th, 1923, to Sept. 14th, 1923,

that I last saw h- alive on Sept. 14, 1923,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Ischio-rectal abscess,
septicemia,
acute cardiac failure.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Sept. 13th

Was there an autopsy? no

What test confirmed diagnosis? clinical findings.

(Signed) James F. White, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 17 1923

20 UNDERTAKER Geo. A. Gilmore

ADDRESS 513 Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates.
TION is very important

SEP 14 1923

Cor.—1-12-22—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79114 178 D79114

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

2-FULL NAME Angelo Charles Alfano

(a) RESIDENCE NO 1918 E. Fairmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Alfano

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saloonkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Bertha Alfano
(Address) 1918 E. Fairmount Ave

15 Filed 151923, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Extensive burns over body- clothes caught fire while putting oit fire at his home.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pneumonia (Autopsy at Hospital) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Patton, M. D.
(Coroner.)

9/15/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 15. 1923
20 UNDERTAKER Martin Dippie.	ADDRESS 37 Ann St

TION is very important. See ... Burial Permit Clerk

Spec.--6-9-19--H. P. Co.--1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79115 — 9-D79115

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 942 W. Mulberry St.: 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wilson Holder

(a) RESIDENCE. No. 942 W. Mulberry St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11, 1923

7 AGE — Years — Months: 7 mos — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry Richmond Holder

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Thomas B. W. I.

12 MAIDEN NAME OF MOTHER: Josephine Rhone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gloucester Co Virginia

14 Informant: Josephine Holder
(Address): 942 W. Mulberry

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1923, to Sept 14, 1923, that I last saw h. alive on Sept. 14, 1923, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pertussis Convulsio

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John E. H. Campbell, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Sept 15 1923

20 UNDERTAKER: John N. Gladmon — ADDRESS: 1077 Lanvale Ave.

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D79116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79116

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Low. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Jones

(a) RESIDENCE NO. 812 Low ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Jones.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	Yrs		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Clara Bowles
(Address) 812 Low City

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 13 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 9 - 1 - , 1923, to 9 - 13 - , 1923, that I last saw him alive on 9 - 12 - , 1923, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

(duration) Indefinite. yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Interstitial nephritis (duration) Indefinite yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Baragik, M. D.

9-13-1923 (Address) 611 - McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Woodbury Cemetery	9/16/1923
20 UNDERTAKER Milton Dawson	ADDRESS 311 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D79117 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D79117

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH University Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 17 WARD)

2-FULL NAME Martha Davis

(a) RESIDENCE NO. 918 Druid Hill Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 years			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Philip Worthem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rose Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Betty Moore
(Address) 918 Druid Hill ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 13, 1923, that I last saw h alive on Sept 13, 1923, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)
3 weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis?

(Signed) J. T. P. Hundley, Jr. M. D.
9/13 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 15, 1923

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1100 Mosher

FP 15 1923 Robert F. Harrison, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that if any ... mation supplied on certificates. See instructions on back of ... TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D79118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79118

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Carey St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Draper Banks

(Residence in Baltimore: No. 1119 N. Carey St.; 72 yrs., 3 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 5 (Day) 1851 (Year)

7-AGE, 72 yrs. 3 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Minister
(b) General nature of industry, business, or establishment in which employed (or employer)? R.C.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Moses Banks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. E. Banks

(Address) 419 Mosher St

15-

Filed SEP 15 1923 191.....

Robert P. Harrison
Burial Permit Clerk.

Registrar.

CAUSE OF DEATH must be stated by physician. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 14 (Day), 1923 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Aug. 23 1923, to Sept. 14 1923, that I saw h[illegible] alive on Sept. 13, 1923, and that death occurred, on the date stated above at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-Sclerosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 5 ds.

(Signed) C. E. [illegible] M. D.

Sept. 15, 1923. (Address) 515 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Ft. Lincoln Cem.

DATE OF BURIAL, Sept. 17, 1923

20-UNDERTAKER Chas. W. Rosenthal

ADDRESS 400 Mosher

Spec—12-23-21—E.B.R.S.—400 Bks.

D79119

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

D79119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2823 Hudson St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. Granbauer

(a) Residence No. 2823 Hudson St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 16, 1921

7-AGE, 1 yrs. 11 mos. 28 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer..... —

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Charles E Granbauer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth L Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Monmouth Co Ind

11 (Informant) Mrs Eloise Whitford

(Address) 511 N Bolton

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13th 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 23 to Sept 13, 23, 19 23

that I last saw h.. alive on Sept 13 1923

and that death occurred, on the date stated above, at 8.50 m.

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Simple Meningitis

(Duration) — yrs. — mos. One ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Kerkard M. D.

(Address) 3100 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cahalawn — DATE OF BURIAL, Sept 17 1923

20-UNDERTAKER, Zickler & Zickler — ADDRESS Eager

In plain terms, so that it may be easily understood. See instructions on back of certificates.

E 25 1923 Robert F. Harrison, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79120

CERTIFICATE OF DEATH.

113 D79120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3907 Phila Ave St., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle E Finley

(a) RESIDENCE NO. 3905 Phila Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-23

7 AGE: Years | Months: 1 | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John G. Finley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Amelia M. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: John G. Finley (Address) 3907 Phila Ave

15 Filed SEP 15 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Sept 14, 1923, that I last saw her alive on Sept 13, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Entertis

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Edocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr J Boyle, M. D.

9-14 1923 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Sept 16 1923

20 UNDERTAKER: Jas C. Fuller — ADDRESS: 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 1-1021-MAT-1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79121 X 21 D79121

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N. Carey ST., 16 WARD)

2-FULL NAME Frank Allen

(a) RESIDENCE NO. 1144 N. Carey ST., ... WARD Charlotte S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
43	1880	Nov	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charlotte S. C.
(State or country)

PARENTS

10 NAME OF FATHER Frank Allen

11 BIRTHPLACE OF FATHER (city or town) Charlotte S C
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Mrs Clara Allen
(Address) 1144 Carey st

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to Sept. 12, 1923, that I last saw him alive on Sept. 12, 1923, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Edward J. Wheatley M. D.

Sept 17 1923 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Sept. 15 1923

20 UNDERTAKER Chas Geo Hooper ADDRESS 406 N Carey st

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

SEP 15 1923 Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D79122

74-001/D79122

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Ethting ST.; 17" WARD)

2-FULL NAME Mary L. Jefferson

(a) RESIDENCE. NO. 1203 Ethting ST., 17" WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Life ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Geo. W. Jefferson

6 DATE OF BIRTH (month, day, and year) Sept. 28 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James W. Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margret Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William J. Jefferson (Son)

(Address) 1203 Ethting St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

FP 51923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-23 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 21st 1923, to Sept 13th 1923, that I last saw her alive on 13th Sept 1923, and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) H F Hill, M. D.

19 (Address) 1208 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

20 UNDERTAKER Jno. M. Johnson

DATE OF BURIAL Sept. 16" 1923

ADDRESS 1309 Druid Hill Ave

May be printed, but CAUSE OF DEATH in plain terms, so that it may be properly coded. See back of certificates. TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79123 90 D79123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1800 Monlandave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Eidman

(Residence in Baltimore: No. 1800 Monlandave St.; 71 yrs., 9 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1851 (Year)

7-AGE, 71 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home pad
(b) General nature of industry, business, or establishment in which employed (or employer): Work

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Erbe

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Smit

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo E Lang

(Address) 1800 Monlaind

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1923, to Sept 13 1923, that I saw h er alive on Sept 13 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Arteria Sclerosis

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 3 yrs. 6 mos. ds.

(Signed) Geo N. Billups M. D.

Sept 14, 1923 (Address) 722 W. Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Parkton — DATE OF BURIAL, Sept 15 1923

20-UNDERTAKER J W W Poulton — ADDRESS 2238 W Balt

CAUSE OF DEATH to be plainly written. Every question important. See instructions on back of certificate.

Robert E. Harrison, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79124 90 D79124

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 Dickman ST. 24 WARD)

2-FULL NAME John Wright

(a) RESIDENCE NO. 205 Dickman ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Baltimore yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katherine M Wright

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	59	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R. 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mana Nilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Katherine M Wright
(Address) 205 Dickman St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to Sept 6, 1923

that I last saw h[illegible] alive on Sept 3, 1923

and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 3 mos 6 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. E. Stevens M. D.

(Address) 1 E Pleasant St. 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmony Grove Md. DATE OF BURIAL 9-18 1923

20 UNDERTAKER E H B Harle ADDRESS 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

SEP 5 1923 Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D79125

HEALTH DEPARTMENT—CITY OF BALTIMORE

52 D79125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2622 Boone St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mackiman Carlton Lewis.

(a) RESIDENCE NO. 2622 Boone St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6 DATE OF BIRTH (month, day, and year): June 15th 1910

7 AGE — Years: 13 Months: 2 Days: 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James H. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Letisha Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs R. A. Elliott

(Address) 1726 Ashland Ave

15 Filed ..... 19 .....

Registrar

Robert P. Harrison, Burial Permit Clerk.

P151923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1923, to Sept 13th, 1923, that I last saw h[illegible] alive on Sept 13th, 1923, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. ..... mos. 1 X ds.

CONTRIBUTORY (Secondary): Rheumatism

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ..... —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm Hunter Stone M. D.

19 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zion Cemetery

DATE OF BURIAL: Sept. 15th 23

UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1726 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79126

CERTIFICATE OF DEATH.

X 11-00 D79126

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Ten Pin Alley ST., 6 WARD)

2-FULL NAME James Owens

(a) RESIDENCE NO 1503 Ten Pin Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	~~white~~ Black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James H. Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James H. Owens
(Address) Berkley Virginia

15 Filed ..... 192 .....
Registrar

Robert P. Garrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broncopneumonia (probably)
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 14 ds.

(Signed) J S Rollins, M. D.
(Coroner.)
9/15/23 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Berkley Va.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Sept 15 1923

20 UNDERTAKER Mrs. R. C. Elliott

ADDRESS 1727 Eastland Av

TION IS very important. See ...

79127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79127 X 113 V D79127

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacques E. Sealock

(Residence in Baltimore: No. Sorrge Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	~~Single~~ X

6-DATE OF BIRTH, Aug. 8, 1923 (Month) (Day) (Year)

7-AGE. ...yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or 1 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Sorrge Md.

PARENTS.

10-NAME OF FATHER, Joseph Sealock

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Dora Riley

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Sealock

(Address) Sorrge Md

15-

Filed ..... 191.....

SEP 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion

.....(Duration).....yrs. 1 mos.....ds.

(Signed) J. H. Pollitt M. D. (Coroner.)

9/15 1923 (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sorrge Md.	9/17, 1923
20-UNDERTAKER	ADDRESS
E. B. Hails	11 E. West St.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79128

CERTIFICATE OF DEATH.

88 D79128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 Eastern ave ST., 16 WARD)

2-FULL NAME Anne A Kraus

(a) RESIDENCE NO. 3226 Eastern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. C. Kraus

6 DATE OF BIRTH (month, day, and year) March 3, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	35	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Zinkand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Fred C Kraus

(Address) 3226 Eastern ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 1923, to Sept 14 1923.

that I last saw her alive on Sept 14 1923

and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Ulcerative Endocarditis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Streptococcus Viridans

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical-Blood Culture

(Signed) Caleb N Bilery M. D.

Sept 14 1923 (Address) 1002 S. Patterson Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Sept 17 1923

20 UNDERTAKER C Schlossmann Son

ADDRESS 1034 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Geisz

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79129 160 D79129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 Hanover ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elaine Laura Geisz

(a) RESIDENCE NO. 1639 Hanover ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 14, 1922

7 AGE: Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Geisz Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Evelyn Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Geisz (Address): 1639 Hanover St.

15 Filed SEP 16 1923 ROBERT R. KRAUTER, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923 to Sept 15, 1923

that I last saw h[illegible] alive on Sept 15, 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed H. L. Campbell M. D.

Sept 16, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Sept 16 1923

20 UNDERTAKER: A. Howard Evans — ADDRESS: 1428 S Charles St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79130

CERTIFICATE OF DEATH.

83 ✓ D79130

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2322 Eutaw Pl ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Katzner

(Residence in Baltimore: No. 2322 Eutaw Pl St.; 33 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	M

6-DATE OF BIRTH, ... (Month) ..... (Day) 1853 (Year)

7-AGE, 80 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Leib Katzner

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Dina Feldstadt

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Baltimore St.

15-

Filed ....., 191.....

Registrar.

SEP 16 1923 ROBERT P. KRANTZ
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Sept 15 1923, that I saw him alive on Sept 15 1923, and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:
Cerebral Softening
Hemiplegia 4 days

(Duration) 6 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. 14 ds.

(Signed) Jos. Friedenwald M. D.

Sept 16 1923 (Address) 1417 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rodef Sholom	Sept 16, 1923
20-UNDERTAKER	ADDRESS
Jac T Lewis	1439 E Balto

CAUSE OF DEATH must be filled in. Answers to questions 16 to 20 inclusive are important. See instructions on back of certificate.

D 79131

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79131 001 D79131

CERTIFICATE OF DEATH.

5 74

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1427 Orleans ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Jones

(a) RESIDENCE. NO. 1427 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col.	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Millie Jones

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Indefinite

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md.

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Lily Jones

(Address) 1427 Orleans St

15 Filed ..... 19..... Registrar

SEP 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 Sept 1923

17

I HEREBY CERTIFY, That I attended deceased from 4 Sept. 1923, to 12 Sept. 1923,

that I last saw h[illegible] alive on 11 Sept. 1923,

and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Vital Organs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edwin Field Boyle, M. D.

19 [illegible] 13 Address) 1427 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 16 1923
20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	1913

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Zygmunt

79132

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79132

HEALTH DEPARTMENT—CITY OF BALTIMORE D79132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 S. Harris Alley ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zygmunt

(a) RESIDENCE. NO. 911 S. Harris Alley ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Zygmunt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Thomas Zygmunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Elizabeth Zygmunt.

(Address) 911 S. Harris Alley.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1 1923, to Sept 13 1923, that I last saw him alive on Sept 13 1923, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. McKenrick M. D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Sept. 17 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Maleska · 79133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79133

CERTIFICATE OF DEATH.

31 D79133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Patterson Park Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Maleska

(a) RESIDENCE. No. 607 S. Patterson Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): August 15. 1870.

7 AGE: 53 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Albert Studzynska

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Katharine Wontkowska 9-14. 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): M. F. Sadowski 905 S. Ann St. 921 Fell St.

15 Filed ... 19 ... Registrar

SEP 16 1923 ROBERT E. KRUG Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Sept 13, 1923, that I last saw her alive on Sept 12, 1923, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronusham M. D.

(Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem., DATE OF BURIAL: Sept 17 1923

20 UNDERTAKER: M. F. Sadowski ADDRESS: 905 S. Ann

CAUSE OF DEATH to be plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

79134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79134

CERTIFICATE OF DEATH.

58-001 D79134

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital. ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Russell

(a) RESIDENCE NO. 1602 Lancaster St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O K

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Serbia

PARENTS

10 NAME OF FATHER John Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Serbia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Serbia

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER.

SEP 18 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 19 23

17 I HEREBY CERTIFY, That I attended deceased from August 18, 19 23, to Sept 14, 19 23,

that I last saw him alive on Sept. 14, 19 23,

and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Sat.

(Signed) Claude A [illegible] M. D.

9-15, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Sept 17. 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski;	705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be readily TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S—400 Bks.

79135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90: D79135 Registered No.

D79135
1-PLACE OF DEATH

City of BALTIMORE: (No. 10 W. Montgomery St., 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorothea Sturm

(a) Residence No. 10 W. Montgomery St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? 85 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Anthony Sturm

6-DATE OF BIRTH (month, day and year) May 1-1837

7-AGE. 86 yrs. 4 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Fredk. Brandt

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Dorothea Grünne

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Germany

11-(Informant) Edw. Sturm

(Address) 10 W. Montgomery

15. Filed SEP 16 1923 ROGER R. KRAUTER, Registrar.

In plain terms, so that it may be understood. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 24 1923 to Sept 14 1923

that I last saw her alive on Sept 13 1923

and that death occurred, on the date stated above, at 7:20 p. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? e

Did an operation precede death? no Date of e

Was there an autopsy? no

What test confirmed diagnosis? C. D. Burdick M. D.

(Signed)

9/15/1923 (Address) 301 East 6th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL. Sept 17 1923

20-UNDERTAKER. F. A. Fraser & Son

ADDRESS 703 Fremont St.

Cor.—1-12-23—M&T—100 Bks.

79136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79136

CERTIFICATE OF DEATH.

74-001

D79136

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Penna Ave ST., 17 WARD)

2-FULL NAME James Wilson

(a) RESIDENCE NO 1130 Penna Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie A. Wilson

6 DATE OF BIRTH (month, day, and year) about 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER ? Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Harriet Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jennie Wilson
(Address) 1130 Penna Ave.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hemmeter M. D.
(Coroner)

Sept. 14, 192 (Address) 2 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenland Gardens N.W.

DATE OF BURIAL 2-17 1923

20 UNDERTAKER Daniel Easton

ADDRESS Ca 2116

SEP 15 1923 ROBERT P. KRAMER
Burial Permit Clerk

FOR A very important

Spec.—1-10-21—M&T—1500 Bks.

79137

166830

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D79137

CERTIFICATE OF DEATH.

REGISTERED NO. D79137

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 15 ST., WARD)

2-FULL NAME William Johnson

(a) RESIDENCE NO. 1379 N Gilmore St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hannah Johnson ~~John Marshall~~

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): W Va

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Record

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1923. 19 , to Sept 14 1923 19 , that I last saw him alive on Sept 14 1923, 19 , and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Primary Aplastic Anemia.

(duration) 0 yrs. 0 mos 26 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, terminal

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. of Blood.

(Signed) D. B. Hannon M. D.

9-15, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charles Town, W. Va.

DATE OF BURIAL: 9-17-1923

20 UNDERTAKER: Daniel Taylor

ADDRESS 916 Gay

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Charles Goldenberg

D 79138

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79138

D79138

CERTIFICATE OF DEATH.

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 W. North ave ST. 15 WARD)

2-FULL NAME Charles Goldenberg

(a) RESIDENCE. NO. 1615 W Northam ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Goldenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS.

10 NAME OF FATHER Isisel Goldenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sidney Goldenberg
(Address) 1615 W North Ave

15 Filed ..... 19 ..... Registrar

SEP 17 1923 ROBERT R. KRAMER,

CAUSE OF DEATH in plain terms, so that it may be properly classified. BARE MEDICAL TERMS WILL NOT BE ACCEPTED. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923 to Sept 15 1923, that I last saw h— alive on Sept 15 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
1 Chronic Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ex. Floyd

(Signed) ..... M. D.

, 19 (Address) 4 1/2 S Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	Sept 17 1923

20 UNDERTAKER J. Ahearn Co ADDRESS 16 W Madison

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79139 90 D79139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 May from mercy St. 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Johannes

(a) RESIDENCE NO. 1913 n mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fr. H Johannes

6 DATE OF BIRTH (month, day, and year) July 9 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer) Silcox Highway
(c) Name of employer [illegible] Co Balto

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry H. Johannes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER H Ramsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fannie Haynes
(Address) 1913 Mulberry

15 Filed SEP 17 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Coma~~ Val disease of heart

Leader (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)

Sept 16, 192 (Address) 1857 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 17 192 3

20 UNDERTAKER Mr Cook — ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D79140

CERTIFICATE OF DEATH.

D79140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 W Saratoga ST., 20 WARD)

2-FULL NAME Henry Doll

(a) RESIDENCE NO. 1903 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Doll

6 DATE OF BIRTH (month, day, and year) Jan 20 1861

7 AGE Years 62 Months Days 24 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md Balto

PARENTS

10 NAME OF FATHER Louis Doll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Sisko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Doll (Address) 1900 W Pratt

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/1923

17 I HEREBY CERTIFY, That I attended deceased from 9/11, 1923, to 9/14, 1923, that I last saw h[illegible] alive on 9/14, 1923, and that death occurred, on the date stated above, at 12:30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hrt

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Kerr Dunn M. D.

, 19 (Address) 1127 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Sept 17 1923

20 UNDERTAKER H Hildebrandt Cor Lan 502 E Lanvale ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Bkly 300 Block Belvedere

Spec.—1-10-21—M&T—1500 Bks.

D79141

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D79141

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5122 Pk Ave ST., 27 WARD)

2-FULL NAME Dorothy Mary Mason

(a) RESIDENCE NO. 5122 Pk. Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ...

6 DATE OF BIRTH (month, day, and year) Sept 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James F Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va.

12 MAIDEN NAME OF MOTHER Opal Hansler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant James F Mason
(Address) 5122 Pk Ave

15 Filed SEP 17 1923, 19 ... Registrar ROBERT R. KRAUTER, Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 . 1923 . to Sept 16 . 1923 . that I last saw h... alive on Sept 15 . 1923 , and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Septic Infection involving skin & mucous membranes and Septic Enteritis

(duration) ... yrs. ... mos 8 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Edgar B Tufenwald, M. D.

. 19 (Address) 1616 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Sept 17 1923 19

20 UNDERTAKER Wm Cook ADDRESS 502 E. Mt Ave

Spec.—1-10-21—M&T—1500 Bks.

D79142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79142

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 11 WARD)

2-FULL NAME Samuel W. Bowham

(a) RESIDENCE NO. 711 N. Calvert St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lather

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Bowham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Reisertown, Md.

12 MAIDEN NAME OF MOTHER Anna Sanderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1923, to September 13, 1923, that I last saw him alive on September 13, 1923, and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 6 mos. (illegible) ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X ray, Lab.

(Signed) Claude G Hence, M. D.

9-14-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Sept 18 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D79143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rode

(a) RESIDENCE NO. 1929 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis H. Rode

6 DATE OF BIRTH (month, day, and year): Jan 18, 1859

7 AGE — Years: 64 — Months: 7 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John McAllister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Francis H. Rode

(Address): 1929 E. Fayette St

15 Filed ..., 19 ... Registrar

ROBERT R. KRAUTER

SEPT 17 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923, to Sept 14, 1923, that I last saw h[illegible] alive on Sept 14, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Rand, M. D.

Sept 17, 1923 (Address) 501 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Sept 17 1923

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Pleasant

CAUSE OF DEATH in plain terms, so that it may be properly classified TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79144

CERTIFICATE OF DEATH.

198 D79144

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Underwood

(a) RESIDENCE NO 304 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Feb. 6/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Martha Wilken (Aunt)
(Address) 304 N. Eden St

15 Filed ..... 192 ..... Registrar

SEP 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage- Stab wound through heart- Autopsy made by Dr. Maldeis City Post Mortem Physican-Oliver Jackson Accused (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pollitt (Coroner.), M. D.

9/17/23 192 (Address) 508 E. NOrth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sept 17th 1923
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

THIS is very important

Spec.—1-10-21—M&T—1500 Bks.

Musto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79145 — CERTIFICATE OF DEATH. — 113 D79145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Gleen Edward Ave ST., 17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicola Musto

(a) RESIDENCE NO. 407 Gleen Edward Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15-1923

7 AGE — Years 7 Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Vincenzo Musto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Vincenza Cusumano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincenzo Musto
(Address) 407 Gleen Edward Ave

15 Filed , 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14th, 1923, to Sept 15th, 1923, that I last saw h in alive on Sept 14th, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. H. Cross, M. D.

, 19 (Address) 2409 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery

DATE OF BURIAL 9/17 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79146

CERTIFICATE OF DEATH.

118-002

D79146

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Torres

(a) RESIDENCE NO. 450 E. Fort Avenue ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Celia Torres

6 DATE OF BIRTH (month, day, and year) 7 July 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) City 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Torres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Magil Englehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Celia M Torres 450 E Fort Ave

15 Filed ..... 19 ..... Registrar

SEP 17 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Sept 14, 1923,

that I last saw h-er alive on September 14, 1923,

and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 450 Fort Ave. Sept 11, 1923

Did an operation precede death? Yes Date of Sept 14, 1923

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Wayland Parrish, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Sept 18 1923

20 UNDERTAKER Tasach Sysor 1600 W North ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79147

CERTIFICATE OF DEATH.

31 D79147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D79147

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1010 W. Fayette ST., 18 WARD)

2-FULL NAME William Morrison Donnelley.

(a) RESIDENCE NO. 1010 W. Fayette. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 4 - 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	21	4	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Donnelley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ruth Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Minnie Donnelley 1010 W. Fayette St.

15 Filed , 19 Registrar

ROBERT R. KRAUTER, SEP 17 1923 Bureau Public Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15- 1923

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1923, to September 15, 1923, that I last saw h in alive on Sept 14, 1923, and that death occurred, on the date stated above, at 3:35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Ruhland, M. D.

9-15, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Sept 18, 1923

20 UNDERTAKER Bowman & Son ADDRESS 901 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79148

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D79148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 E. Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Trageser

(a) RESIDENCE NO. 1008 E. Biddle ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter E. Trageser

6 DATE OF BIRTH (month, day, and year) March 2nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magaret Sallendad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Peter E. Trageser (Address) 1008 E Biddle St

15 Filed SEPT 7 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11th 1923, to Sept 15th 1923, that I last saw h[illegible] alive on Sept 15th 1923, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) Coma yrs. mos 1 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Stone M. D.

(Address) 1801 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Sept. 19 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1801 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D79149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79149

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Aliceanna ST., 2 WARD)

2-FULL NAME Walerya . Malinowski

(a) RESIDENCE NO. 1922 Aliceanna ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael . Malinowski

6 DATE OF BIRTH (month, day, and year) Feb. 26 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	59	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John. Goralski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary .Steczkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Michael . Malinowski

(Address) 1922 Aliceanna St.

15 Filed SEP 17 1923, 19 ... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Sept. 16, 1923, that I last saw h[illegible] alive on Sept 16, 1923, and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy ..... (duration) ... yrs. ... mos 1 ... ds.

CONTRIBUTORY (Secondary) Hemiplegia (left side) (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger M. D.

(Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Sep 18 1923

20 UNDERTAKER John McWeber

ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D79150 HEALTH DEPARTMENT—CITY OF BALTIMORE D79150

Y88-03

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1303 N. Montford Ave ST., 8 WARD)

2-FULL NAME Joseph J. Cobb

(a) RESIDENCE NO 1303 N. Montford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Cobb

6 DATE OF BIRTH (month, day, and year) April 11/1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md. Casuality Co.

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Cobb

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margaret Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mary V. Cobb
(Address) 1303 N. Montford Ave

15 Filed....., 192 ..... Registrar

D 177023

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thoracic Hemorrhage- struck by Automobile- crushed chest rt. side

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cole, M. D.
(Coroner.)

9/17/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 18 1923
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

Spec.—1-10-21—M&T—1500 Bks.

D79151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 : D79151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Old Orchard Rd ST., 28 WARD)

2-FULL NAME Mary Louisa Hoffrogge

(a) RESIDENCE NO. Old Orchard Rd ST., 11 WARD Ten Hills

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian H Hoffrogge

6 DATE OF BIRTH (month, day, and year) June 18 1849

7 AGE Years 74 Months 2 Days 28 If LESS than 1 day, brs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Fredk. Dill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E Eitle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Christian H Hoffrogge

(Address) Old Orchard & 27th

15 Filed . 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to Sept 15 1923.

that I last saw h alive on Sept 15 1923,

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J Fenderich Leitz, M. D.

Sept 19 1923 (Address) 2040 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Sept 17 1923

20 UNDERTAKER Wm Tickner & Sons ADDRESS Norfolk

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME Sam Schuman

(a) RESIDENCE. NO. 13 S. Eden ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Schuman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore

15 Filed SEP 17 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Sept 16, 1923, that I last saw him alive on Sept 16, 1923, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Ascites

(duration) yrs. mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Isidore I. Fry, M. D.

9/16, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Woodlawn Circle Road 9/17 1923

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E Baltimore

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79153

CERTIFICATE OF DEATH.

40 D79153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2745 W North Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel W. Kirkwood

(a) RESIDENCE NO. 2745 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emma J Kirkwood

6 DATE OF BIRTH (month, day, and year) Nov 14 1855

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs. or ... min.
	67	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliz. C Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) G A C Md

14 Informant Mrs Emma J Kirkwood

(Address) 2745 W. North ave

15 Filed ... 19 ... Registrar

SEP 17 1923

ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923. to Sept 15 1923.

that I last saw him alive on Sept 14 1923.

and that death occurred, on the date stated above, at 12 35 a m.

The CAUSE OF DEATH* was as follows:

Cardio Sclerosis

Chronic

Myocardidis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. H. C. Ulman, M. D.

(Address) 2757 W. North ave

9/16/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Sept 18 1923

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79154

CERTIFICATE OF DEATH.

129 D79154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2042 Cecil ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Eben

(a) RESIDENCE NO. 2042 Cecil ave ST., 9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 16 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Day Printing Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry G. Eben

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary A. Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Harry G. Eben

(Address) 2042 Cecil ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept. 14, 1923,

that I last saw him alive on Sept. 14, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos 24 hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary analysis

(Signed) Benj. L. Hamby M. D.

9/14 1923 (Address) 1216 N. Carlton st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park.

DATE OF BURIAL: Sept. 17, 1923.

20 UNDERTAKER: Robt F. Turner Inc

ADDRESS 1412 W Broadway

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79155 .

CERTIFICATE OF DEATH.

45 ✓ D79155

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 N. Caroline St ST., 8 WARD)

2-FULL NAME William A. Burnett

(a) RESIDENCE NO. 1129 N. Caroline ST., 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie V. Burnett.

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant. 645

(b) General nature of industry, business, or establishment in which employed (or employer) Burlap Bag Co.

(c) Name of employer Owner.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Michael D. Burnett.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma J. Wood

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Annie V. Burnett
(Address) 1129 N. Caroline st.

15 Filed ..... , 19 ..... Registrar

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Sept 15, 1923, that I last saw him alive on Sept 15, 1923, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7/29/23.

Was there an autopsy? No

What test confirmed diagnosis? Examination etc.

(Signed) Herman J. Dorf, M. D.

, 19 (Address) 3730 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept. 18 1923
20 UNDERTAKER	ADDRESS
Mrs. Albert E. Fuller	Harford Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

First organ involved
Intestines

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79156

101-001 D79156

D79156

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N. Woodyear ST., 16 WARD)

2-FULL NAME ~~Birdie~~ Birdie Estelle Murdock

(a) RESIDENCE NO. 724 N. Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Chinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Elizabeth Murdock

(Address) 724 N. Woodyear St.

15 Filed , 19 Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or terms that may be misunderstood. Do not report symptoms or modes of dying, but the diseases which caused them. Do not report conditions which did not contribute to the cause of death. Do not report on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 15 , 1923 , to Sept 16 , 1923 ,

that I last saw h alive on Sept 15 , 1923 ,

and that death occurred, on the date stated above, at 3:40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Riland. , M. D.

9-16, 1923 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL Sept 18 1923

20 UNDERTAKER Wm H. Reed Sons

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79157

CERTIFICATE OF DEATH.

38 D79157

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1353 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Genevie Johnson.

(a) RESIDENCE. NO. 353 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic - 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mother -

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Nelson Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg Va

12 MAIDEN NAME OF MOTHER Eliza Jane Spruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oxford Md

14 Informant Eliza Jane Johnson (Address) 1353 Woodyear

15 Filed SEP 17 1923, 19.... ROBERT R. KRAUER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to Sept. 14, 1923, that I last saw her alive on Sept 13, 1923, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 2 3/4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) William A Wright, M. D.

(Address) 1209 Brookman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn.	Sept 18 1923
20 UNDERTAKER James H. Dennis	ADDRESS 303 Lexington St.

CAUSE OF DEATH to be plainly written. See instruction on back of certificates. TION is very important.

Spec. 6-3-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D79158

D79158

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Brent ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Maud & Maya Burroughs

(a) RESIDENCE. NO. 1729 Brent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Maya Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maud James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Maya Burroughs 1729 Brent Street

15 Filed . 19 ROBERT R. KRAMER Registrar

SEP 17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/10, 1923, to 9/16, 1923.

that I last saw h[illegible] alive on 9/16, 1923, 4 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Stillborn (6 months Birth)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhart, M. D.

, 19 (Address) 1729 Brent

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Sept 18 1923

20 UNDERTAKER James N. Lewis — ADDRESS 303 Presstman St.

CAUSE OF DEATH in plain terms, stating the disease, and not the mode of dying. Such terms as heart failure, asthenia, etc., without a statement of the cause of the condition, are not sufficient. Indefinite or local terms, such as abscess, cancer, gangrene, etc., should not be used without stating the nature of the disease of which they are symptoms. Consumption should be stated as pulmonary or tuberculosis of the lungs, and not by any of its local names. Deaths from violence must state the means and nature of injury, and whether accidental, suicidal, or homicidal. Deaths during childbirth must state the cause of the condition. Deaths from any of the diseases dangerous to the public health must be reported immediately by telephone or otherwise. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79159 46 D79159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 N Kenwood Ave WARD 7)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Andreae

(a) RESIDENCE No. 635 N Kenwood Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theodore Andreae

6 DATE OF BIRTH (month, day, and year): March 23-1870

7 AGE: 53 Years; Months 5; Days 9; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Caprile

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Margaret McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Theodore Andreae (Address) 635 N Kenwood Ave

15 Filed ..... 19 ..... Registrar

SEP 17 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to Sept 15, 1923, that I last saw h alive on Sept 14, 1923, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and adjacent organs.

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical Exam

(Signed) [illegible] M. D.

Sept 17, 1923 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Sept 19 1923

20 UNDERTAKER: Wm. T. Hartley — ADDRESS: 859 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79160

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D79160

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park Height ne Slade Ave ST., 27 WARD)

2-FULL NAME Rose Burgmuder

(a) RESIDENCE NO. Park Height ne Slade Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Burgmuder

6 DATE OF BIRTH (month, day, and year): June 24/1861

7 AGE — Years: 62 — Months: 2 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Seligman Berneri

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): B Berneri Park Height ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1923

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1922, to Sept 16, 1923, that I last saw h[illegible] alive on Sept 16, 1923, and that death occurred, on the date stated above, at 12 25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Bone metastases 1 year
Primary in breast - 12 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of January 19 1911

Was there an autopsy? No

What test confirmed diagnosis? Microscopic of Growth & Rem of bones

(Signed) Louis P Hausburger, M. D.

Sept 17, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew — DATE OF BURIAL: Sept 18 1923

20 UNDERTAKER: David Gendheim — ADDRESS: 118 n Mt Royal

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

SEPTEMBER ROBERT R. KRAUTER Burial Permit

Spec—12-23-21—E.B.R.S.—400 Bks.

D79161

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D79161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 221 S. Gilmor St. ..... St., 19 ..... Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number.)

2-FULL NAME. Mary J. Dowling .....

(a) Residence No. 221 S. Gilmor St. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 24 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Dowling

6-DATE OF BIRTH (month, day and year) June 17, 1853

7-AGE. 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Bayden

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Susan Arnold

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Ireland

14- (Informant) Mrs Dowling

(Address) 221 S Gilmore St

15-

Filed ..... 192 ..... Registrar.

SEP 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

In plain terms, so that it may be easily understood, state cause of death. Follow instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 16, '23

17- I HEREBY CERTIFY, That I attended deceased from September 13, 1923 to September 16, 23

that I last saw her alive on " 15, 1923

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis .....

..... (Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? " .....

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cahalan, M. D

9/17, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL, Sept 19, 1923

20-UNDERTAKER. Wm J Fields — ADDRESS 200 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

D79162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79162

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Ashland ST., 10 WARD)

2-FULL NAME Ella L. Standley

(a) RESIDENCE NO. 1103 Ashland ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph. Stanley

6 DATE OF BIRTH (month, day, and year): April 1874

7 AGE — Years: 49 — Months: 5 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Chas. H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Ella Berryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Joseph Stanley 15 S. E. Monument St

15 Filed ..., 19 ... Registrar

CAUSE OF DEATH to be plainly written, so that every word can be read. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3 1923. to September 14, 1923.

that I last saw her alive on September 14. 1923.

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Brights Disease & complication of Disease (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Brights Disease & Complication Disease (duration) yrs. 8 mos. 16 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. R. Gilbert M. D.

9-15, 1923 (Address) 708 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westbury, Md.

DATE OF BURIAL: 9/18 1923

20 UNDERTAKER: Jas. M. Kimmel

ADDRESS: 625 E. Madison

Spec.—1-10-21—M&T—1500 Blks.

D79163

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79163

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2681 (Dulaney) (ST.,) 20 (WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt E L Johnston

(a) RESIDENCE NO. 2681 Dulaney ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1920

7 AGE — Years: 3 — Months: 1 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm F Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Olga McCracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Wm F Johnston
(Address) 2681 Dulaney St.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/15, 1923, to 9/16, 1923,

that I last saw h alive on 9/15/23, 19.....,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) James R Chrystie, M. D.

9/16, 1923 (Address) 1729 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 9/17 23

20 UNDERTAKER: George A Tinley Sutton & Smyth — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

SEP 17 1923 ROBERT R. KRAUTER Burial Permit Issued

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79164

CERTIFICATE OF DEATH.

91-002 D79164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maple & Smith Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Jordan

(a) RESIDENCE NO. Maple & Smith Ave. ST., 27 WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 73 yrs. 5 mos. 29 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Jordan

6 DATE OF BIRTH (month, day, and year) 3. 17. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Jordan

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Welch

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co (State or country) Md

14 Informant Miss Blanche Jordan (Address) Fort Washington Md

15 Filed SEP 17 1923 Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1922, to Sept 15, 1923, that I last saw him alive on Sept 15, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Arterio Sclerosis —

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Bleeton M. D.

10. 15. 1923 (Address) Fort Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept 18 23

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS 108 W. NORTH AVE.

D79165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1885 D79165

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Fr. Sq. Hospital St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rowland E. Reed.

(Residence in Baltimore: No. 2013 Hollins St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

6-DATE OF BIRTH. Dec 28th 1875
(Month) (Day) (Year)

7-AGE. 47 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Storage Mfg
(b) General nature of industry, business, or establishment in which employed or employer. 2367 Reder Lane

9-BIRTHPLACE. (State or Country) Cambridge Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Cambridge Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M Reed

(Address) 2013 Hollins St

15-

Filed ..... 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 14 192.3
(Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Frontal Bone. accident.

(Duration) ..... yrs. ..... mos. 7 hrs. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Black M. D.
(Coroner.)

Sept 23 192.3 (Address) 143 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Balto Cemetery DATE OF BURIAL. Sept 17 192.3

20-UNDERTAKER. F. B. Hufnagel ADDRESS 2236 Eutaw

State CAUSE OF DEATH very carefully. See instructions on back of certificate. This is very important.

Spec.—8-24-1[illegible]—M. & T.—2000 Bks.

D79166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D79166

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2055 McHenry ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Oswald

(Residence in Baltimore: No. 2055 McHenry St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 15, 1884 (Month) (Day) (Year)

7-AGE, 38 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

9-BIRTHPLACE, (State or Country), Hungary

PARENTS.

10-NAME OF FATHER, Peter Oswald

11-BIRTHPLACE OF FATHER (State or Country), Hungary

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. E. Oswald

(Address) 2055 McHenry St

15-

Filed SEP 17 1923, 191.....

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Sept. 13 1923, that I saw h[illegible] alive on Sept 13. 1923, and that death occurred, on the date stated above, at 6-00 m.

The CAUSE OF DEATH* was as follows:

Sleeping Sickness

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Intracerebral Haemorrhage (Duration) [illegible] yrs. [illegible] mos. ds.

(Signed) J. H. Pilson M. D.

Sept 16, 1923 (Address) 331 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Sept 17, 1923

20-UNDERTAKER F. B. Hufford ADDRESS 22 S. Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79167 HEALTH DEPARTMENT—CITY OF BALTIMORE 7400 ✓ D79167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Port St. 6 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Merritt

(a) RESIDENCE. No. 423 N. Port St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of Catherine Merritt

6 DATE OF BIRTH (month, day, and year) Sept 15th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William Merritt

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Catherine Merritt (Address) 423 N. Port St

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1923, to Sept. 15, 1923, that I last saw h~~im~~ alive on Sept. 15, 1923, and that death occurred, on the date stated above, at 5-40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 8 hrs.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Supposed

(Signed) J. C. Braithwaite, M. D.

(Address) 1531 E. North Ave

9-15-23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 19th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1120 E Monument St

SEP 17 1923 ROBERT R. KRAUTER Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks. Ernest Reynold Truman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79168 ~~D79168~~ D79168

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Bay View Hospital 19 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Truman (Gurnan)

(a) RESIDENCE No. 1511 W. Lexington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Truman

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital Balto. Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923 to Sept 15, 1923 that I last saw him alive on Sept 15, 1923 and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. J. Goldsmith M. D.

9/16/23 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Sept 17 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 537 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

SEP 17 1923

Spec.—1-10-21—M&T—1500 Bks.

Schumacher

D79169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D79169

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. Carolina ST., 9 WARD)

2-FULL NAME Margaria Schumacher

(a) RESIDENCE NO. 1814 N. Carolin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, ~~or Divorced~~. (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: Lud. Jams. Schumacher

6 DATE OF BIRTH (month, day, and year): Oct. 31, 1861

7 AGE: Years 62. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Annapolis Md.

PARENTS

10 NAME OF FATHER: Matthew Tempe.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs. M. Pyott. (Address) 1701 Maryland ave

15 Filed ..., 19... Registrar

SEP 17 1923 ROBERT R. KRAUDER Bureau Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 15, 1923, that I last saw her alive on Sept 14, 1923, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines
+ Acute Dilitation of Heart

(duration) 1 yrs. mos 3 Hours ds.

CONTRIBUTORY (Secondary): Carcinoma of Intestines

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Carman, M. D.

9-17, 19... (Address) 1707 N Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept. 17 1923

20 UNDERTAKER: George F. Roth

ADDRESS: 1835 Harford ave.

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79170 X 90 D79170

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1203 John St ST.: 11 WARD)

2-FULL NAME Rebecca Weisenburger

(a) RESIDENCE. No..... Philadelphia Pa WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Weisenburger

6 DATE OF BIRTH (month, day, and year) Jan 27 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ODO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura E Krout
(Address) 1203 Johns St

15 Filed ..., 19.....
Registrar

CAUSE OF DEATH. Be particular. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Sept 16, 1923, that I last saw h— alive on Sept 15, 1923, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart - Dilatation.

Sudden (duration) — (Found dead)

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

9. 17. 1923 (Address) 354 Chestnut, Pa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa DATE OF BURIAL: Sep 19 1923

20 UNDERTAKER: OHENOWETH & SON ADDRESS: 3617 CHESTNUT AVE

ROBERT R. KRAUTER, Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79171

CERTIFICATE OF DEATH.

113 D79171

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N Caroline ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Wood

(Residence in Baltimore: No. 921 N Caroline St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 7 ..... (Month) (Day) (Year)

7-AGE, ...yrs. 18 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Wood

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nellie Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elliott

(Address) 1725 Bakerland Ave

15-

Filed....., 191.....

SEP 17 1923 ROBERT H. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923, to Sept 15 1923, that I saw h[illegible] alive on Sept 15 1923, and that death occurred, on the date stated above, at 11 15 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) R J [illegible] M. D.

9 17, 1923. (Address) 1429 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Laurel

DATE OF BURIAL, Sept 18, 1923

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Bakerland

important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79172

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH.

D79172

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 43 E. Hamilton Ave St., Hamilton Md Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John L. Hornick

(a) Residence No. 43 E. Hamilton Ave St., Hamilton Md Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, ~~Widowed,~~ or Divorced, (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine H. Hornick

6-DATE OF BIRTH (month, day and year) April 9 - 1860

7-AGE, 63 yrs. mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Proprietor of Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto Md
(State or Country).

PARENTS.

10-NAME OF FATHER, William Hornick

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country).

12-MAIDEN NAME OF MOTHER, Fredericka

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country).

14- (Informant) Catherine Hirschl Hornick wife

(Address) 43 E. Hamilton Ave Home

15- Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1923 to Sept 15 1923 that I last saw him alive on Sept. 14 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion heart weakness

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? 1101 Harlem Ave

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. H. Hubert, M. D.

Sept 17, 1923 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL, Sept 18th 1923

20-UNDERTAKER. Henry C. Brannigan Son — ADDRESS 517 N. Edmondson

SEPT 7 1923

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79173

CERTIFICATE OF DEATH.

X 90 D79173

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes' Hospital

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

2-FULL NAME Mrs. Elizabeth Ball

(a) RESIDENCE NO. ..... Ellicott City ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ... mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Jno. Ball

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Peter Beckett Unknown

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAJEWSKI
Burial Permit Clerk

SEP 17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923, to Sept. 15, 1923, that I last saw h e alive on Sept. 15, 1923, and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency
Femoral thrombosis
Pulmonary embolism

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) M. Alexander Novey, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Della Cemetery — DATE OF BURIAL Sept. 17 1923

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with the use of certificates. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79174

CERTIFICATE OF DEATH.

44

Registered No. D79174

1-PLACE OF DEATH

City of BALTIMORE: (No. 2056 Eastern Ave St., 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Papa

(a) Residence No. 2056 Eastern Ave St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Papa

6-DATE OF BIRTH (month, day and year) June 1862

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Fruit

(b) General nature of Industry, business, or establishment in which employed (or employer)... Dealer

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Papa

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Santa Festa

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Italy

14- (Informant) Mr Jos Papa

(Address) 2056 Eastern Ave

15- Filed ... 192... Registrar.

ROBERT R. KRAUTER
SEP 17 1923
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 1923 to Sept 16 1923, that I last saw h. alive on Sept 12 1923 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of None 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C Freeman, M. D.

Sept 16 1923 (Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 18 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2000 Eastern Ave

instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D79175

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sullivan

(a) Residence No. 16 3 E Eutaw Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9/14/23

7-AGE, ...yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Edward Sullivan

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country),

12-MAIDEN NAME OF MOTHER, Catherine Sullivan

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Hospital Records

(Address).....

15- Filed..... 192.....

SEP 17 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/17/23

17- I HEREBY CERTIFY, That I attended deceased from 9/14/23, 19..... to 9/17/23, 19.....

that I last saw h alive on 9/17/23, 19.....

and that death occurred, on the date stated above, at 2:26 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Atelectasis

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sollers Hebrew Cem. DATE OF BURIAL. 9/17/23

20-UNDERTAKER David Sondheim ADDRESS 1119 Wilmot Royal Ave

In plain terms, so that it can be understood. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D79176

CERTIFICATE OF DEATH.

D79176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Curtis

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 13, 19 23, to Sept 14, 19 23.

that I last saw h[illegible] alive on Sept. 14, 19 23.,

and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis

(Hypertrophic)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G Thomas, M. D.

9-1, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

85

UNIVERSITY OF MARYLAND SEP 17 1923

ROBERT R. KRAUTER (Assistant Health Commissioner & Medical Permit Clerk.)

SEP 17 1923

D79177 HEALTH DEPARTMENT—CITY OF BALTIMORE D79177

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 S. Catherine St., W Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H Bee

(Residence in Baltimore: No. 4 S Catherine St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept. (Month) 22 (Day) 1854 (Year)

7-AGE. 68 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Helper
(b) General nature of Industry, business, or establishment in which employed (or employer): B&O Railroad

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Henry Bee

11-BIRTHPLACE OF FATHER. (State or Country). England

12-MAIDEN NAME OF MOTHER. Jane Montgomery

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate M. Whiteford

(Address) 1948 W. Pratt St.

15- SEP 17 1923 Filed.. 192.. L K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. T. B.

(Duration) Yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) Yrs. mos. ds.

(Signed) Geo Chester Blades M. D.

Sept 16 1923 (Coroner) (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Sept 17" 1923

20-UNDERTAKER. Geo L B Cook ADDRESS 1003 N. Dallas St

This Certificate is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D79178

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home - Chestnut Hill ave ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Brinston

(Residence in Baltimore: No. St. Elizabeth's Home - Chestnut Hill ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	black	

6-DATE OF BIRTH, November (Month) 16 (Day), 1922 (Year)

7-AGE, ...yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Citycharge

11-BIRTHPLACE OF FATHER (State or Country), No information

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) ....

15- Robert F. Harrison, OH

Filed ..... 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 28 1923, to September 16 1923, that I saw her alive on September 17 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

....

....

Measles

.... (Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

.... (Duration) ....yrs. ....mos. 17 ds.

(Signed) Frank J. Ayd M. D.

Sept 17, 1923 191... (Address) 1205 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL | DATE OF BURIAL. ....., 191...

20-UNDERTAKER | ADDRESS

Burial Permit Cl...

SEP 17 1923

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79179

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) University Parkway (St.) and Guilford Ave. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Forbes.

(a) RESIDENCE No. Temple Court Apt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Bessie M. Forbes

6 DATE OF BIRTH (month, day, and year): Sept 26 1873.

7 AGE — Years: 46 Months: 6 Days: 26. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Bell Foundry Co

9 BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS

10 NAME OF FATHER: Alonzo Forbes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Ella Peck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Bessie M. Forbes.

(Address) Temple Court Apt.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 16 1923

17

I HEREBY CERTIFY, That I attended deceased from June 23 . 1923 . to Sep 16 . 1923 .

that I last saw h[illegible] alive on Sep 16 . 1923 ,

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of intestines & liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of About June 1

Was there an autopsy? no

What test confirmed diagnosis? Operation & Autopsy

(Signed) Wm T Watson, M. D.

Sep 17 1923 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Seneca Falls N Y — DATE OF BURIAL: Sept 17 1923

20 UNDERTAKER: John A Mitchell — ADDRESS: 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

P 71923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79180 D79180

CERTIFICATE OF DEATH.

175

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cooks Lane (Ten Hills) ST., 28 WARD)

2-FULL NAME Mary Belle E. Cook

(a) RESIDENCE NO. Cooks Lane (Ten Hills) ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Cook

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice G. Hoff

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant John A. Cook
(Address) Cooks Lane (Ten Hills

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from 4.30 P.M. 1923. to 11. P.M. 1923.

that I last saw h-- alive on Sept. 15th 1923.

and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:

Death due to Ptomaine poisoning (over)

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thurney L. Davis, M. D.

, 19 (Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Sept 18 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Paca

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

SEP 17 1923 Robert P. Harrison

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Eating Crabs

Spec—12-23-21—E.B.R.S.—400 Bks.

D79181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

D79181

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 South Monroe St., 19th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Matilda Schubert.

(a) Residence No. 605 South Monroe St., 19th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. 11 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schubert.

6-DATE OF BIRTH (month, day and year) Sept. 6th, 1868.

7-AGE.	If LESS than 1 day.
55 yrs. — mos. 10 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany.
(State or Country).

PARENTS.

10-NAME OF FATHER, John Jacob Hiller.

11-BIRTHPLACE OF FATHER (city or town) Germany.
(State or Country).

12-MAIDEN NAME OF MOTHER, Barbara Hiller.

13-BIRTHPLACE OF MOTHER (city or town) Germany.
(State or Country).

14- (Informant) Mrs. Rena Imhoff (Sister).....
(Address) 1925 West Lombard Street.....

15-
Filed..... 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 16, 1923.

17- I HEREBY CERTIFY, That I attended deceased from April 28th, 1923, to September 16, 1923, that I last saw her alive on September 16th, 1923, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Small spindle-cell sarcoma of left superior maxillary bone.

(Duration) One yr. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary embolism.

(Duration) Three-quarters of an hour.

18-Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic.

(Signed) C. W. G. Rohrer, M. D.

, 19 (Address) 22 Ailsa Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cem	Sept 19th, 1923
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Paca St

In giving information required under this head, please see instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79182 ✓ 101-001 D79182

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Penrose Ave. ST., 20 WARD)

2-FULL NAME John Thomas Abell

(a) RESIDENCE NO. 2107 Penrose Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mabel Frances

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Beauvue St. Marys County
(State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Abell

11 BIRTHPLACE OF FATHER (city or town) St. Marys County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Joy

13 BIRTHPLACE OF MOTHER (city or town) Calvert County
(State or country) Maryland

14 Informant Harry C. Stesch
(Address) 527 Loudon Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 17, 1923.

that I last saw h[illegible] alive on Sept 16, 1923.

and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:
Sub phrenic abscess (10 days)
Laparotomy

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Laparotomy & Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted ——
if not at place of death? .....

Did an operation precede death? — Date of — — —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. A Coolahan, M. D.

9/17 1923 (Address) 24 N Gilmor Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 19 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Calvert St

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. Omission of any item will delay registration of certificates. TION is very important. See instructions on back of certificate.

SEP 17 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79183 D79183

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Heath

(a) RESIDENCE NO. Exeter (ST.) Maryland (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 hours ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Joseph's Hospital (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Spencer Heath.

11 BIRTHPLACE OF FATHER (city or town) Fairfax County (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ada Lee Sept. 17

13 BIRTHPLACE OF MOTHER (city or town) Birmingham (State or country) England

14 Informant (Address) Hosp. Records

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Sept 16, 1923, that I last saw him alive on Sept 16, 1923, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

2 Days.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Lungs.

(Signed) F. C. Richardson, M. D.

(Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Sept 18, 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

P 7 1923

Robert F. Carrion, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D79184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D79184

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Mc Henry ST. 19 WARD)

2-FULL NAME Carman E Hedrick

(a) RESIDENCE NO. 1804 Mc Henry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9, 1920

7 AGE — Years: — Months: 3 Days: 7 If LESS than 1 day, ... hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Gladys Hetherington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Gladys G. Hedrick
(Address) 1804 Mc Henry St

15 Filed SEP 18 1923 ROBERT P. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept-16, 1923, that I last saw her alive on Sept-16, 1923, and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) James Nicholson M. D.

9/17, 1923 (Address) 1729 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept. 18 1923

20 UNDERTAKER: George L. Schwab — ADDRESS: 1201 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in other parts of the country. Use no abbreviations or ditto marks. Be particular and definite. Do not state mode of dying, as shock, exhaustion, or heart failure, without assigning the disease causing this condition. If from accident, violence, or casualty, state the nature of injury and how received. If from a specific disease, state whether a primary, secondary, or complicating cause. If from childbirth, state whether single or multiple, and whether before, during, or after labor. If from any disease peculiar to women, state definitely. If from old age, state principal diseases and contributing causes, if any. If a woman, state whether single, married, widowed, or divorced. This information is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79185

CERTIFICATE OF DEATH.

100-001 ✓

D79185

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 23 WARD)

2-FULL NAME Alfred Woodford

(a) RESIDENCE NO. 1000 Leadenhall St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed SEP 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to Sept. 16, 1923,

that I last saw him alive on September 15, 1923,

and that death occurred, on the date stated above, at 5:15 A.M.

The CAUSE OF DEATH* was as follows:

Senile Detenation

Senile Dementia

Chron. Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (Senile)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. F. Hess M. D.

9-16-23 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Sept 18 1923
20 UNDERTAKER	ADDRESS
G. F. Bloxom and Son	Cambridge

CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79186

CERTIFICATE OF DEATH.

14 D79186

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 528 N. Pine St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. N. Hamilton

(Residence in Baltimore: No. 528 N. Pine St.

St.; 58 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, August 17, 1865
(Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Sam. Hamilton

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Hamilton

(Address) 528 N. Pine St.

15-

Filed SEP 18 1923, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of years 5 mos

(Duration) yrs. mos. ds.

(Signed) Chas. Hammann M. D.
(Coroner.)

Sept 15 1923 (Address) 2102 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery

DATE OF BURIAL, Sept 17 1923

20-UNDERTAKER J. Ward Hall

ADDRESS 1212 Pine

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79187

CERTIFICATE OF DEATH.

74-001

D79187

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Argyle Ave ST., 14 WARD)

2-FULL NAME Thomas Weston

(a) RESIDENCE NO. 1440 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3-880

7 AGE 43 Years 4 Months 13 Days | If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ralph Weston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cecilia Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Same 1440 Argyle Ave

15 Filed ..... 19 ..... Registrar

CAUSE OF DEATH to plain terms. Abbreviations are not to be used. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1923. to Sept 16. 1923.

that I last saw him alive on Sept 16, 1923

and that death occurred, on the date stated above, at 4.50 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Broncho Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D L W Kennard M. D.

9-17. 1923 (Address) 708 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery | DATE OF BURIAL Sept 18 1923

20 UNDERTAKER George A. Fetter | ADDRESS 1631 Orig Ave

SEP 1 8 1923 ROBERT R. KRAUTER, REGISTRAR

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79188

CERTIFICATE OF DEATH.

113 D79188

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Thames St. ST., 2 WARD)

2-FULL NAME Walter Zachimowicz

(a) RESIDENCE NO. 1622 Thames ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Walter Zachimowicz

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Majka.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Walter Zachimowicz.

(Address) 1622 Thames St.

15 SEP 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1923, to Sept 16, 1923, that I last saw him alive on Sept 16, 1923, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Monrovia, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Hamiltons. Cem.	Sept. 18. 1923
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D79189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Parker

(a) RESIDENCE NO 326 N. Schroeder ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie M. Parker

6 DATE OF BIRTH (month, day, and year): Aug 11 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blender
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. Baltimore Md

PARENTS

10 NAME OF FATHER: Abraham Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Porter
(Address): 326 N Schroeder St

15 Filed ..., 192 SEP 18 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to by death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull accidentally fell down [illegible] (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. J. [illegible] (Coroner) M. D.

Sept 17, 1923 (Address) 1639 Druid

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., 1 mos., dys. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Gregory Cem — DATE OF BURIAL: Sept 18 1923

20 UNDERTAKER: J. Edward Co. — ADDRESS: [illegible]

INSTRUCTION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79190

CERTIFICATE OF DEATH.

90 D79190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 4800 Tark Heights Av ST.: 27 WARD)

2-FULL NAME Andrea P. Caldwell

(a) RESIDENCE. NO. 4800 Tark Heights Av ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of
(or) ~~WIFE of~~ Mrs A. Caldwell.

6 DATE OF BIRTH (month, day, and year) Apr 26 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, X hrs. or min.
	43	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Goods

(c) Name of employer F. A. Davis & Son Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrea P. Caldwell Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrell Jr. Maryland

12 MAIDEN NAME OF MOTHER Clara Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Leo J. Cummings

(Address) 265 W Hamilton

SEP 18 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Sep 17, 1923

that I last saw h alive on Sep 17, 1923

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Dubert M. D.

, 19 (Address) 4801 Tark Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept 20 1923

20 UNDERTAKER ADDRESS

Michael Doyle 15 E Lee

Spec.—1-10-21—M&T—1500 Bks.

D79191 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79191

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH Saint Agnes Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellad, Forker

(a) RESIDENCE NO. 227 No. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Joseph B Forker

6 DATE OF BIRTH (month, day, and year): Dec 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62	—	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Saml Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Mrs Helen Morton

(Address) 227 No Carrollton ave

15 Filed SEP 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1923, to Sept. 17, 1923, that I last saw h e alive on Sept. 17, 1923, and that death occurred, on the date stated above, at 2.05 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Blood examination

(Signed) M. Alexander Novey M. D.

SEP 17 1923, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary Holly N. J.

DATE OF BURIAL: SEP 20 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE

CAUSE OF DEATH to plain terms, so that ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The Interstate Registrar

Spec.—1-10-21—M&T—1500 Bks.

D79192 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D79192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R Leidenman

(a) RESIDENCE NO. 1926 Fulton Ave WARD 16th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ray Leidenman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hackford

PARENTS

10 NAME OF FATHER Louis Leidenman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bessie Hepner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jack Lewis

(Address) 1439 E Balto St

SEP 18 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1923, to Sept. 16th, 1923, that I last saw him alive on Sept 16th, 1923 and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Cardio. Renal insufficiency

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Embolism Pneumonia Thrombus (duration) yrs. 2 mos. 5 ds. 2

18 Where was disease contracted if not at place of death? 1926 Fulton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray + Lab.

(Signed) — Pitcock, M. D.

(Address) 2232 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 9/18 1923

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be published. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79193

CERTIFICATE OF DEATH.

X 129 D79193

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Mercy Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lillie Butler

(a) Residence No. Union Bridge Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. —mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Butler

6-DATE OF BIRTH (month, day and year) 1893.

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Md

(State or Country).

PARENTS

10-NAME OF FATHER. Brightful Grant

11-BIRTHPLACE OF FATHER (city or town). Md.

(State or Country).

12-MAIDEN NAME OF MOTHER. Katie Thompson

13-BIRTHPLACE OF MOTHER (city or town). Md.

(State or Country).

14- (Informant). Hospital Records

(Address).

15- Filed 193. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/12/23

17- I HEREBY CERTIFY, That I attended deceased from 9/5/23 19 to 9/12/23 19

that I last saw h. alive on 9/11/23 19

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

7

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia & Cardiac Failure

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Examination

What test confirmed diagnosis?

(Signed) W. W. Talley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Unionbridge Md

DATE OF BURIAL. Sept 20 1923

20-UNDERTAKER. W M Pontious

ADDRESS 723 N Wolfe

In placing cause of death, see instructions on back of certificates.

SEP 18 1923

Spec—12-23-21—E.B.R.S.—400 Blks.

D79194 HEALTH DEPARTMENT—CITY OF BALTIMORE D79194

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U S Marine Hosp No 1 12 Registered No. 129

City of BALTIMORE: (No. ..... St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Russell

(a) Residence No. U S Marine Hosp No 1 St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
60 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Mrs Smith

(Address) U. S. Marine Hosp No 1

12- Filed SEP 18 1923 J. K. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16/23

17- I HEREBY CERTIFY, That I attended deceased from 4/0 19 3 to 9/16 19 23, that I last saw him alive on 9/16/23 19 23 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:
Subacute Parenchymatous Nephritis

No data (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No data

Did an operation precede death? No Date of 9/16/23

Was there an autopsy? No

What test confirmed diagnosis? Febrile & Chemical

(Signed) J. C. Graves M. D

Sept 16, 1923 (Address) U S Marine Hosp No 1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL. 9/18 19 23

20-UNDERTAKER. J. Lawrason & Bro — ADDRESS 1127 E Balto st

In printing, follow instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79195

CERTIFICATE OF DEATH.

129 D79195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1054 N. Milton Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Columbus Wilson

(a) RESIDENCE NO 1054 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 31/1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Reamer
(b) General nature of industry, business, or estuhlishment in which employed (or employer) Sparrows Pt. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Lewis C.Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER xxxx Kent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William J.Wilson (Brother)
(Address) 727 St. Peters St.

15 [illegible] SEP 18 1923 J. S. R. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Uremia- chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Fuller, M. D.
(Coroner.)
9/18/23, 192 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Sept 18 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Bks.

D79196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E. 27th ST., 12 WARD)

2-FULL NAME Mary Elizabeth Calligan

(a) RESIDENCE NO. 319 E 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Calligan

6 DATE OF BIRTH (month, day, and year): Nov 25 1862

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 357

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Benjamin Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Matilda Hed-

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs E A Dunmore 319 E 27th St

Filed SEP 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1922 to Sept 16th, 1923.

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 7-30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Sept

DATE OF BURIAL: 18 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

D79197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79197

134-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4212 Ridgewood Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Walter Gardner Smith

(a) Residence No. 4212 Ridgewood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or ~~WIFE of~~) Minnie P Smith

6-DATE OF BIRTH (month, day and year) March 31/1866

7-AGE. 57 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Coal trader and Farmer ~~Retired~~

(b) General nature of industry, business, or establishment in which employed (or employer). Retired 6/6

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Sykesville Montgomery Co Md

PARENTS.

10-NAME OF FATHER, Joseph R Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER, Margaret E Gardner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Montgomery Co Md

14- (Informant) Minnie P Smith

(Address) 4212 Ridgewood Ave

15- Filed SEP 18 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 17th 1923

17- I HEREBY CERTIFY, That I attended deceased from April, 1923 to Sept 17th 1923

that I last saw h.. alive on Sept 15th 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Recto-Vesical fistula followed by cystitis - and ascending pyelo nephritis

Chronic ulcer (Duration) 23 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Uraemia -

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? 4 times Date of -

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Wm. J. Gardner M. D.

, 19 (Address) Relay Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Sept 19, 1923
20-UNDERTAKER	ADDRESS
Harry A Annacott	4204 Ridgewood Ave

In plain terms, see instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Chester . Kolb

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79198

CERTIFICATE OF DEATH.

10 D79198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 S. Chapel ST., 7 WARD)

2-FULL NAME Chester Kolb

(a) RESIDENCE NO. 227 S. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Martin. Kolb

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Moniewski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr Martin . Kolb
(Address) 227 S Chapel Street

15 Filed SEP 18 1923 ROBERT R. REMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1923, to Sept. 17, 1923, that I last saw him alive on Sept. 16, 1923 and that death occurred, on the date stated above, at 12 20 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rohberger, M. D.

(Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sep 18 1923

20 UNDERTAKER: John H Weber — ADDRESS: 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D79199

D79199

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 E North Ave (St.) 12 (Ward)

2-FULL NAME John W. Hoffman

(a) RESIDENCE No. 213 E. North Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie B. Hoffman

6 DATE OF BIRTH (month, day, and year) January 26 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H Hoffman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Annie B. Hoffman
(Address) 213 E. North Ave

15 Filed SEP 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Sept 17th, 1923, that I last saw him alive on Sept 17th, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3½ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Some yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Watson, M. D.

Sept 17, 1923 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Sept 19, 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

CAUSE OF DEATH to plain terms, so that no abbreviations or technical terms may be used. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79200

CERTIFICATE OF DEATH.

90 ✓ D79200

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 West North Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Belle Gray

(Residence in Baltimore: No. 830 West North Ave St.; 40 ~~84~~ yrs., ~~2~~ mos. ~~20~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.)
Female	white	widow

6-DATE OF BIRTH, April 24, 1839.
(Month) (Day) (Year)

7-AGE, 84 yrs. 4 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Dist of Columbia

PARENTS.

10-NAME OF FATHER, William Stettinius

11-BIRTHPLACE OF FATHER (State or Country), Dist of Columbia

12-MAIDEN NAME OF MOTHER Rosina Crammer

13-BIRTHPLACE OF MOTHER (State or Country), Dist of Columbia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. M. Gray

(Address) 830 W. North Ave.

Filed SEP 18 1923 HUBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1923, to Sept 17 1923, that I saw her alive on Sept 17 1923, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Cardiac Circulation

30 days

(Duration) yrs. 4 mos. 13 ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(Duration) yrs. 1 mos. ds.

(Signed) Chas Elbert Judd M. D.

9/17, 1923 (Address) 1701 Madison Ave Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Easton Md. DATE OF BURIAL, Sept. 19, 1923

20-UNDERTAKER John A. Mitchell ADDRESS 1121 E. Fayette St.

important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Bks.

D79201

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 113 ✓ D79201

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Green ST., 22 WARD)

2-FULL NAME James Gilbert McCreery

(a) RESIDENCE NO. 509 S. Green ST., ... WARD 8.6.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May, 9, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Wimsboro
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Gilbert McCreery

11 BIRTHPLACE OF FATHER (city or town) Fairfield Co
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Virginia Simyard

13 BIRTHPLACE OF MOTHER (city or town) Fairfield Co.
(State or country) South Carolina

14 Informant Gilbert McCreery
(Address) 509 S. Green St

SEP 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept, 16, 1923, to Sept, 18, 1923, that I last saw him alive on Sept, 17, 1923, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Davis Dranelin M. D.

9/18, 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment D. C

DATE OF BURIAL Sept 18 1923

20 UNDERTAKER Edward Bryon

ADDRESS 1631 Arlington Ave

CAUSE OF DEATH to be filled in plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79202

16-007 D79202

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Phelps Lane ST., 20 WARD)

2-FULL NAME Charles J. Schwab, Jr.

(a) RESIDENCE NO. 1 Phelps Lane ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? 1 yrs. 8 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan. 5- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	1	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles J. Schwab

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie B. Enos

13 BIRTHPLACE OF MOTHER (city or town) Howard County (State or country) Maryland

14 Informant Charles J. Schwab (Address) 1 Phelps Lane

15 Filed SEP 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17- 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Sept. 17, 1923, that I last saw him alive on Sept. 16, 1923, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) C. W. Shilling, M. D.

9/18, 1923 (Address) 1120 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 19th 1923.

20 UNDERTAKER Geo. L. Schwab. — ADDRESS 210 Frederick Ave.

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79203 ✓ D79203

D79203

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 227 E. Hamburg St., 2d WARD)

2-FULL NAME Jack A. Lettau

(a) RESIDENCE NO. 227 E Hamburg ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11 1923

7 AGE — Years: ..... Months: ..... Days: 6 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Chas A Lettau

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belgium Ohio

12 MAIDEN NAME OF MOTHER: Alice M. Zobel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Chas A. Lettau
(Address): 227 E Hamburg St

15 Filed SEP 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923 to Sept 17, 1923
that I last saw h alive on Sept 17, 1923
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 Mos. Utero Gestation
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H E Campbell M. D.

Sept 18, 1923 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Sept 18 1923

20 UNDERTAKER: E Schloman & Son — ADDRESS: 1009 Hanover

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79204 129 D79204

D79204

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Madison ave ST., 13 WARD)

2-FULL NAME William H. Roberts Jr

(a) RESIDENCE NO. 2235 Madison ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Bank Cashier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm H. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Elizabeth D. Dobler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Miss Roberts (Address) 223 S. madison ave

15 Filed SEP 16 1923 .19.. ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16—1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to September, 1923, that I last saw him alive on September 16, 1923, and that death occurred, on the date stated above, at 11 15 Pm.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm J. Leadbetter M. D.

19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 9/19 1923

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1810 W Mt Royal ave

CAUSE OF DEATH to plain terms, so that no one may misunderstand. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79205

101-001

D79205

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 104 Park Ave. Raspeburg ST., 12 WARD)

2-FULL NAME George Leonard

(a) RESIDENCE NO. 104 Park Ave. Raspeburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Leonard

6 DATE OF BIRTH (month, day, and year) Dec 17th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	—	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Stove Foundry

(c) Name of employer Shepard & Co.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Jacob Grace
(Address) 104 E. Park Ave.

15 Filed SEP 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Sept 17, 1923, that I last saw him alive on Sept 17, 1923, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) L. Pneumonia followed by Bronchitis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. A. Fait, M. D.

9/17, 1923 (Address) Fulton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Sept 19 1923
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fulton

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79206 46 D79206

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3 Kolb Ave Ward) St. Raykeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Dangerfield

(Residence in Baltimore: No. 3 Kolb Ave. Rayeburg St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, March (Month) 6 (Day), 1867 (Year)

7-AGE 55 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Alley Heusner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Victoria Schwab

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Dangerfield

(Address) 3 Kolb Ave. Rayeburg.

SEP 18 1923

Filed ..... [illegible] Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 30, 1923, to Sept 16, 1923, that I saw h[illegible] alive on Sept 15 1923, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH was as follows:

Cancer Uteras
was operated on
at 1 Year ago

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. D. Cornell M. D.

Sept 17, 1923 (Address) Corse & Downs

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Sept. 19, 1923

20-UNDERTAKER Fredk Lasch & Sons — ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79207 164 D79207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 N. Bradford ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Straube

(a) RESIDENCE No. 1606 N. Bradford ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Straube

6 DATE OF BIRTH (month, day, and year): Sept 11th 1845

7 AGE: Years 78 | Months — | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown Germany

PARENTS

10 NAME OF FATHER: Reinhold Rheinbauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Germany

12 MAIDEN NAME OF MOTHER: Hermina Kellerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Germany

14 Informant (Address): Herman Straube 1606 N. Bradford St.

15 Filed ..... 19 ..... Registrar

SEP 18 1923 ROBERT M. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923. to Sept 17, 1923.

that I last saw h[illegible] alive on Sept 17, 1923.

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage of Age.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Ernest G. Leupold M. D.

, 1923 (Address) 628 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Cemetery

DATE OF BURIAL: Sept. 20 1923

20 UNDERTAKER: Fredk. Loose & Sons

ADDRESS: Fullerton

CAUSE OF DEATH to be filled in plain terms, and must not be indefinite or insufficient. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79208

HEALTH DEPARTMENT—CITY OF BALTIMORE

13 / D79208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1206 Linden Avenue St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sabastien Odendhal

(a) Residence No. 1206 Linden Ave. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie C. McGraw

6-DATE OF BIRTH (month, day and year) Feb. 28, 1830

7-AGE.	If LESS than 1 day.
93 yrs. 6 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Retail
(b) General nature of industry, business, or establishment in which employed (or employer) Leather Merchant
(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), France

PARENTS.

10-NAME OF FATHER, Jean B. Odend'hal

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), France

12-MAIDEN NAME OF MOTHER, Catherine Mercier

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), France

14-

(Informant) Mrs. Annie C. Odend'hal

(Address) 1206 Linden Ave.

15-

SEP 18 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

All physicians are required to answer every question as far as practicable. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 16, '23

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923 to Sept. 16, 1923.

that I last saw him alive on Sept. 16, 1923

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hydro-nephroma

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? ".....

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

9/17, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	9-19, 1923

20-UNDERTAKER.	ADDRESS
Henry W. Mearse Son	805 N. & Calvert

Spec.—1-10-21—M&T—1500 Bks.

D79209 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X/100-001 D79209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N Gilmor ST., 16 WARD)

2-FULL NAME William Henry Jackson

(a) RESIDENCE NO. 1107 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		13 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron

(b) General nature of industry, business, or establishment in which employed (or employer): Iron

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Prince Edward Co. Va

PARENTS

10 NAME OF FATHER: Harry Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Edward Co.

12 MAIDEN NAME OF MOTHER: Rosie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Campbell Co.

14 Informant: Harry Jackson

(Address): 1107 N Gilmor St

15 Filed , 19 Registrar

Robert F. Barrison, Burial Permit Clerk.

SEP 18 1923

CAUSE OF DEATH IS plain terms, and TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/18/1923

17 I HEREBY CERTIFY, That I attended deceased from 9/16/, 1923, to 9/18/, 1923,

that I last saw h. in alive on 9/18/, 1923

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Jackson M. D.

Sept. 19 23 (Address) 767 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Buckville Va — DATE OF BURIAL: Sept 19 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: Ashland

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79210

CERTIFICATE OF DEATH.

49 D79210

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. 141 W Lanvale ST. 11 WARD)

2-FULL NAME Benjamin Truman Fendall

(a) RESIDENCE No. 141 W Lanvale ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 5 1851

7 AGE: Years 71 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pub Serv Com

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexander (State or country) Virginia

PARENTS

10 NAME OF FATHER Townshend Fendall

11 BIRTHPLACE OF FATHER (city or town) Alexander (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Eches

13 BIRTHPLACE OF MOTHER (city or town) Alexander (State or country) Virginia

14 Informant B Mason Fendall
(Address) 141 W Lanvale St

15 Filed ..... 19 ..... Robert P. Harris ..... Registrar
Burial Permit Clerk.

P 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1923 to Sept 18 1923, that I last saw h alive on Sept 8 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gallstones

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Aug 23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C B Lumpkin Jr M. D.

, 19 (Address) 2 E Mt Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Front Royal Va

DATE OF BURIAL: Sept 19 1923

20 UNDERTAKER: Henry W Jenkins & Sons Co

ADDRESS: Eutaw & Lanvale Sts

CAUSE OF DEATH to be plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79211

CERTIFICATE OF DEATH.

X 3/ D79211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ward 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lee

(a) RESIDENCE NO. 1418 Morton ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Phila, Pa.

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 29 - Months - Days - If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER: unknown -

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Hospital Record

(Address)

15 Filed: SEP 18 1923

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1923, to Sept. 15, 1923.

that I last saw h[illegible] alive on Sept. 15, 1923

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis -

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Anthony V. Bruno M. D.

, 19 (Address) Municipal Hosp. -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Sept 19 1923

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1725 Oakland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79212

CERTIFICATE OF DEATH.

101-001 ✓ D79212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12-N-Bruce St., 19 WARD)

2-FULL NAME Samuel Thomas

(a) RESIDENCE NO. 12-N-Bruce ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Thomas

6 DATE OF BIRTH (month, day, and year) 11-7-1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Hampton Va

PARENTS

10 NAME OF FATHER Allen Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanoverville Va

12 MAIDEN NAME OF MOTHER Susan Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Co Va

14 Informant Sister (Wife) (Address) 12-N-Bruce St

15 Filed SEP 18 1923 Robert P. Harrison, Registrar

Burial Permit Clark

CAUSE OF DEATH in plain terms, so that it may be properly... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Sept 16, 1923, that I last saw him alive on Sept 16, 1923, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. Walker Johnson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 18 1923
20 UNDERTAKER	ADDRESS 114 E
Brown's Funeral Home	

D79213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79213

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 824 Harlem Av St.; 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur T. House

(Residence in Baltimore: No. 824 Harlem Ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, April 6, 1845
(Month) (Day) (Year)

7-AGE, 78 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Hartford Conn

PARENTS.

10-NAME OF FATHER, Tameman B House

11-BIRTHPLACE OF FATHER (State or Country), Conn.

12-MAIDEN NAME OF MOTHER, Sarah Ann Hubbard

13-BIRTHPLACE OF MOTHER (State or Country), Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. House

(Address) New Britain Conn

15-

Filed Sept. 19 1923 Robert P. Garrison
Registrar.

P 18 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept 19, 1923 (Address) 2102 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL National

DATE OF BURIAL, SEP 20 1923 19...

20-UNDERTAKER Geo W Little

ADDRESS 2102 EDMONDSON AVE.

CAUSE OF DEATH must be plainly written. All items important. See instructions on back of certificate.

Spec.—1-12.23—M&T—500 Blks.

D79214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79214
D. 79214
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Valley Road near Hamilton Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline N. Sindall

(a) RESIDENCE NO. Valley Road Hamilton ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Late David Sindall

6 DATE OF BIRTH (month, day, and year) 12/29/1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. Sindall
(Address) Valley Road Hamilton

15 Filed 9/18, 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

P 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 16, 1923, that I last saw h[illegible] alive on Sept 16, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
(Primary Hypostatic)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Simmons, M. D.
9/18, 1923 (Address) 497 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cem Govans

DATE OF BURIAL 9/19 1923

20 UNDERTAKER George J Ruth

ADDRESS 1135 Hanford Ave

TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79215

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2640 Dulaney ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Hamm Masenheimer

(a) RESIDENCE No. 2640 Dulaney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 10-1914

7 AGE: Years 8 Months 10 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Chas H. Masenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington Md

12 MAIDEN NAME OF MOTHER: Lucy Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Chas H. Masenheimer 2640 Dulaney St

15 Filed 9/18 1923, 19 Robert P. Garrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH: If plant worker, so state. Information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923 to Sept 18, 1923, that I last saw h[illegible] alive on Sept 18, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

9/18, 1923 (Address) 547 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 19th 1923

20 UNDERTAKER: F. B. Ruppert — ADDRESS: 2316 Fulton Ave

Spec.—1-10-21—M&T—1500 Bks.

D79216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 138 D79216

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hallie Spriggs

(a) RESIDENCE NO. South River ST., Anne Arundel Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 week How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Blk

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907.

7 AGE Years 16 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South River Anne Arundel Md

PARENTS

10 NAME OF FATHER Newton Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rachel Thomas

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital Records.

(Address)

15 Filed SEP 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1923, to Sept. 16, 1923.

that I last saw her alive on Sept 16, 1923,

and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured Ovarian Abscess

(Colon bacillus infection)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 16-23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) R. B. Cyller M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camp Loval Md DATE OF BURIAL 9-17-23

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

CAUSE OF DEATH to plainly written or typewritten. See instructions on back of certificates. TION is very important.

D79217 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79217

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 519 N Vincent St. 19 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Geo E Gray (If not over one day, ... hrs. ..... min.)
(Residence in Baltimore: No. 517 N Monroe St. 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH. 1866
(Month) (Day) (Year)

7-AGE. 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). .....

9-BIRTHPLACE, (State or Country). Md.

PARENTS

10-NAME OF FATHER. [illegible]

11-BIRTHPLACE OF FATHER. (State or Country) [illegible]

12-MAIDEN NAME OF MOTHER. [illegible]

13-BIRTHPLACE OF MOTHER. (State or Country) [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E Gray
(Address) 517 N Monroe St

SEP 19 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Office

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Dil Stomach
Error of Diet
as Independent
(Duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Exhaustion
(Duration) ..... mos. ..... ds.

(Signed) Geo Claudius Bloedel M. D.
(Coroner.)
Sept 18 1923 (Address) 1431 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem
DATE OF BURIAL. 9-19- 1923

20-UNDERTAKER. David Carter & Co
ADDRESS 516 Cathedral

Be very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79218

REGISTERED NO. 9 D79218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3828 Hickory Ave (WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Mc Kelly

(a) RESIDENCE. NO. 3828 Hickory Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apl 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George McNelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Finn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George McNelly (Address) 3828 Hickory Ave

15 Filed SEP 19 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 23, to Sept 18 23, that I last saw h[illegible] alive on Sept 17 23, and that death occurred, on the date stated above, at 930 A m.

The CAUSE OF DEATH* was as follows:

Intoxication

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. [illegible] M. D.

9/18 1923 (Address) 1701 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys, Hampden	Sep 19 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE

CAUSE OF DEATH and place of burial. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D79219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Mulberry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie Wynn

(Residence in Baltimore: No. 1511 Mulberry St.; 5yr yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Widowed

6-DATE OF BIRTH, unknown (Month) (Day) about 1871 (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE, TO THE ~~BEST OF~~ MY KNOWLEDGE.

(Informant) John Gregerson

(Address) 1509 Mulberry St

15- SEP 19 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 1923, to Sept 15 1923, that I saw h[illegible] alive on Sept 15 1923, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. T. Grimm M. D.

9/17, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ashley Cemetery

DATE OF BURIAL, Sept 19th, 1923

20-UNDERTAKER Milton Davis

ADDRESS 315 N Edwards St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79220

CERTIFICATE OF DEATH.

90 D79220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Wilcox ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Dougherty

(a) RESIDENCE NO. 1123 Wilcox ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? Life yrs. , mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1° 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy at.

(b) General nature of industry, business, or establishment in which employed (or employer) St Johns School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas J. Dougherty

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Rose M. Harris

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Mr. Thomas J. Dougherty (Address) 1123 Wilcox St.

15 Filed SEP 19 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15 1923 to Sept 16 1923 that I last saw him alive on Sept 16 1923 and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. Gill Hall M. D.

(Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Amelia — DATE OF BURIAL Sept. 20 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of Pneumonia
a few years back

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79221

113

D79221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 Carswell ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anetta. M. Bush

(a) RESIDENCE NO. 1641 Carswell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry D. Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edith P. Denny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Harry D. Bush

(Address) 1641 Carswell St.

15 Filed SEP 19 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923 to Sept 17, 1923 that I last saw h[illegible] alive on Sept 16, 1923 and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signature J. L. E. Campbell M. D.

Date 9-17-23 (Address) 1644 Lancaster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Sept. 19 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E. Eager St.

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79222 D79222

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Nicholas Nigut

(a) RESIDENCE NO. Seven md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Nigut

11 BIRTHPLACE OF FATHER (city or town) (State or country) German.

12 MAIDEN NAME OF MOTHER Teresa Schilk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant University Hospital (Address)

SEP 19 1923

Filed . 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 12. 1923. to Sept 15. 1923.

that I last saw him alive on Sept 15, 1923,

and that death occurred, on the date stated above, at 1.55 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with Uremia.

Cardiac decompensation with Hemorrhagic oedema

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) D. R. Hendon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND Commissioner Health SEP 19 1923

CAUSE OF DEATH must be filled in all cases. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

Esta Holmes

D79223

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D79223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2217 Druid Hill Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esta Holmes

(a) Residence No. 2217 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Col

5-~~Single~~, Married, Widowed, ~~or Divorced~~. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jefferson Holmes

6-DATE OF BIRTH (month, day and year) 1858

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Virginia (State or Country)

PARENTS.

10-NAME OF FATHER Smith Braxton

11-BIRTHPLACE OF FATHER (city or town) Virginia (State or Country)

12-MAIDEN NAME OF MOTHER Annie Waylon

13-BIRTHPLACE OF MOTHER (city or town) Virginia (State or Country)

14 (Informant) Martha Gardner

(Address) 2217 Druid Hill Ave

15- Filed SEP 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Sept 15 1923

that I last saw h— alive on Sept 15 1923

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam. —

(Signed) R. Garland Ellicott M. D.

Sept 18, 1923 (Address) 1534 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bay View — DATE OF BURIAL, Sept 19, 1923

20-UNDERTAKER. James A. Dennis ADDRESS 130 E Fredrick

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79224 ✓ 124 D79224

CERTIFICATE OF DEATH.

D79224

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 4028 Hickory Ave ST., 13 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie M. Cook

(a) RESIDENCE NO. 4028 Hickory Ave ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. N. Cook

6 DATE OF BIRTH (month, day, and year) Nov. 2-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	71.	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicotts City Maryland

PARENTS

10 NAME OF FATHER Henry Bartell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Clarisa Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Lydia M. Edelman

(Address) 4028 Hickory Ave

15 Filed SEP 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Sept 16, 1923, that I last saw her alive on Sept. 16, 1922, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia, Interstit. Nephritis

Arteio-Sclerosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's, Hamden	Sept. 19 1923
20 UNDERTAKER Horace H. Burgee	ADDRESS 313 Falls Road

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D79225

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-601 D79225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 S. Sharp St (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Randall Johnson

(a) RESIDENCE NO. 710 S. Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	88 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER Anna Rideout

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Elizabeth Prout
(Address) 710 Sharp St

15 Filed SEP 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 17, 1923,

that I last saw him alive on Sept 17, 1923,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:—

Pneumonia Lobar

(duration) — yrs mos 21 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles R. Forbes, M. D.

(Address) 712 S. Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. National Ct — DATE OF BURIAL Sept 20 1923

20 UNDERTAKER H. W. Brown & Son — ADDRESS 1032 W. Pratt

CAUSE OF DEATH to be given in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

D79226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED No. D79226

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 617 Greenwillow St.; 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dinn Tompkins

(Residence in Baltimore: No. 617 Greenwillow St. St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, about ....., 1878
(Month) (Day) (Year)

7-AGE, about 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Arkansas

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country),
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eliza Gains
(Address) 617 Greenwillow St

15- SEP 19 1923 ROBERT R. KRAUTER,
Filed ....., 191... Burial Permit Clerk.
Registrar.

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Neumann M. D.
(Coroner.)

Sept 19 1923 (Address) 218 Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem.	Sept 19, 1923
20-UNDERTAKER	ADDRESS
R. J. Kemsley.	518 N Bridle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79227

CERTIFICATE OF DEATH.

161-001 D79227

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1376 N. Stricton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ernest Mason, Jr.

(a) RESIDENCE: NO. 1376 N. Stricton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Ernest Mason Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles County, Md.

12 MAIDEN NAME OF MOTHER Ida Gebrue, 9/18, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles County, Md.

14 Informant Ida Mason, (Address) 1376 N. Stricton St

15 Filed SEP 19 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1923, to Sept. 17, 1923, that I last saw him alive on Sept. 17, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(7 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Hospital.

(Signed) John D. Quinlin, M. D.

(Address) 1501 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Iron Cemetery — DATE OF BURIAL: Sept. 20 1923

20 UNDERTAKER: Clarence E. Wisbell — ADDRESS: 1364 Mary

CAUSE OF DEATH to plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79228

D79228

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 S. Durham ST., 2 WARD)

2-FULL NAME Mary Wegner

(a) RESIDENCE NO. 518 S. Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wegner.

6 DATE OF BIRTH (month, day, and year) Oct 2, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Wabnitz Rogulsk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant W. F. Sadowski; for John Wegner (Address) 518 S. Durham St.

SEP 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1923, to Sept. 17, 1923.

that I last saw her alive on Sept. 15, 1923

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. P. Neu, M. D.

(Address) 408 S. Bond Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Hamilton. DATE OF BURIAL Sep. 20, 1923

20 UNDERTAKER W. F. Sadowski; ADDRESS 708 S. Ann.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79229

CERTIFICATE OF DEATH.

74-001

D79229

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4909 Raford Ave 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Anna M Pitterhoff

(a) Residence No. 4909 Raford Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced [illegible] (or) WIFE of Ernest Pitterhoff

6-DATE OF BIRTH (month, day and year) Nov 20 1853

7-AGE, 69 yrs. 9 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Lohmuller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, [illegible] Knoop

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Ernest Pitterhoff

(Address) 4409 Raford Ave

SEP 19 1923

ROBERT R. KRAUTER,
Registrar.
Bureau of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 17. 1923.

17- I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 17, 1923.

that I last saw h[illegible] alive on Sept 17, 1923.

and that death occurred, on the date stated above, at 5.15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) C Carl Sauer, M. D.

Sept 18 1923 (Address) 4706 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Parkwood	Sept 20 1923
20-UNDERTAKER.	ADDRESS
H Feemann	324 Broadway

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79230

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D79230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Falk

(a) RESIDENCE NO. 1715 Appleton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Falk

6 DATE OF BIRTH (month, day, and year) Nov 14 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Balto.

PARENTS

10 NAME OF FATHER Jacob Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Fannie Habel

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Julius Falk (Address) 1715 Appleton St

15 Filed SEP 19 1923 By Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 16 1923 to Sept 18 1923.

that I last saw h alive on Sept 18 1923

and that death occurred, on the date stated above, at 3:20 m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Arteriosclerotic gangrene

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9-15-23

Was there an autopsy? No

What test confirmed diagnosis? Arteriosclerotic gangrene

(Signed) [illegible], M. D.

(Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 9/19/1923

20 UNDERTAKER David Sondheim ADDRESS 118-20 Mt. Royal

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79231

113 D79231

1 PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 812 N. Carey ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfield N. Butler

(a) RESIDENCE NO. 812 N. Carey ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 29-1923

7 AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	19	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER George Butler

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Hooper

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Rochester Co. Md.

14 Informant Ellen Butler (Address) 812 N. Carey St.

15 Filed SEP 19 1923 ROBERT R. KRAUTER Burial Permit Issued Registrar

CAUSE OF DEATH to print terms, so that it may be of certificates. See instructions on back TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18- 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16- , 1923 , to Sept. 18- , 1923 , that I last saw him alive on Sept. 18- , 1923 , and that death occurred, on the date stated above, at 11-10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) — yrs. 2 weeks mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. P. Cem. DATE OF BURIAL Sept 19 1923

20 UNDERTAKER Sam'l H. Glass & Son ADDRESS 1400 Walker

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79232

CERTIFICATE OF DEATH.

6 129

REGISTERED NO. D79232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Jefferson St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malicia Howe

(Residence in Baltimore: No. 1505 Jefferson St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, October 1923
(Month) (Day) (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O K O

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Howe cor Aisquith

(Address) 1505 Jefferson St

15- SEP 19 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1923, to Sept 17 1923, that I saw him alive on Sept 17 1923, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Mitral insufficiency

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) yrs. mos. 3 ds.

(Signed) R. J. Young M. D.

9/19, 1923 (Address) 1429 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville — DATE OF BURIAL, 9/20, 1923

20-UNDERTAKER Sheridan White — ADDRESS 113 E Mulb.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D79233

CERTIFICATE OF DEATH.

D79233

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1024 N. Bay ST.:) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Dressel

(a) RESIDENCE. NO. 1024 N Bay st ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22nd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Leonhardt Dressel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hofmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Dressel (Address) 1024 N. Bay st

15 Sep 19 1923 ROBERT R. KRAUTER Registrar

Registration District No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1923 to Sept 16th 1923

that I last saw h alive on Sept 16th 1923

and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt L Kinsey, M. D.

19 23 (Address) 1501 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept 21st 1923

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 112 E Monument st

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

To attach history

Spec.—1-10-21—M&T—1500 Bks.

D79234

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79234

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Fremont-Ave ST., 10 WARD)

2-FULL NAME William F. Rabbey

(a) RESIDENCE NO. 1011 Fremont-Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ant Kunn

6 DATE OF BIRTH (month, day, and year) April 11 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Danl Kunn

11 BIRTHPLACE OF FATHER (city or town) Danl Kunn

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Kunn

13 BIRTHPLACE OF MOTHER (city or town) Danl Kunn

(State or country)

14 Informant Ida Burkins

(Address) 1011 Fremont-Ave

15 Filed SEP 19 1923, 19 ..... Registrar

ROBERT N. KRAUTER

BUREAU REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to Sept 18, 1923,

that I last saw him alive on Sept. 17, 1923

and that death occurred, on the date stated above, at 3-15 p m.

The CAUSE OF DEATH* was as follows:

Dilated Heart Arteriosclerosis

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Cystic Induration.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Patrick M. D.

Sept 19, 1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — Sept 20 1923

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Fayette

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D79235

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

199 D79235

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E. Fort Ave. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael T. McDonald.

(a) RESIDENCE No 1501 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 26th. 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	11	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John McDonald.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen M. Dunne.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Ellen M. Dunne. (mother)
(Address) Fairfield, Md.

15 SEP 19 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 16th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) & autopsy find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
knocked down in a fight.
Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Rosenau M. D. (Coroner.)

Sept. 19, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. a.a.Co

DATE OF BURIAL Sept 20 1923

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79236

CERTIFICATE OF DEATH.

Registered No. C-91-002 D79236

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt. Hygeia 2203 Market St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H Carll.

(Residence in Baltimore: No. Mt. Hygeia 2203 Market St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. August (Month) 17 (Day) 1846 (Year)

7-AGE. 77 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman 186
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Carll

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Carll

(Address) 2203 Market st Mt Hygeia

15-

Filed SEP 19 1923 192 ROBERT B. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ca Pneumonia

(Duration) yrs. mos. ds.

(Signed) Asa Emma Bladel M. D. (Coroner)

Sept 17 1923 (Address) 1432 E Baltimore

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 20 1923

20-UNDERTAKER.	ADDRESS
George J Smith	1532 Hollins

is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D79237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79237

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Harford av ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Fritze

(a) RESIDENCE NO. 2500 Harford av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Fritze

6 DATE OF BIRTH (month, day, and year) Nov 20 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	80	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Mecklenburg (State or country) Germany

PARENTS

10 NAME OF FATHER dont Know

11 BIRTHPLACE OF FATHER (city or town) dont Know (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Chas G Fritze

(Address) 2500 Harford av

15 SEP 19 1923 Burial Permit Clerk

HERMAN R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 1, 1923 to Sept 17, 1923.

that I last saw him alive on Sept 16, 1923.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) T. J. Kinzey, M. D.

, 19 (Address) 2500 Harford av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cem Violetville	Sept 21 1923
20 UNDERTAKER	ADDRESS
George J Smith	1532 Hollins

CAUSE OF DEATH must be given. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D79238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79238

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 E Fairmount ave ST.; 6 WARD)

2-FULL NAME Capt. Paul G. E. Rossi

(a) RESIDENCE. No. 2018 Fairmount ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 3- 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not any of kind Gives

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary McLellan

(Address) 2018 Fairmt

15 Filed SEP 19 1923 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1923, to Sept 17, 1923, that I last saw him alive on Sept 16, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Salcrosis and Chronic Endocarditis Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage — Coma (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) Geo. L. McKeon M.D.

, 19 (Address) 224 E 39 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 9/20 1923

20 UNDERTAKER J. A. Moran — ADDRESS 200 E Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79239

CERTIFICATE OF DEATH

D79239

REGISTERED NO.

1-PLACE OF DEATH (Hallins Henry Roock) 25

CITY OF BALTIMORE: (No. Lakeland ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter LeRoy Warner (6½ mo)

(a) RESIDENCE. NO. Lakeland St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
	no	no	no	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Emory Warner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Kellholtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emory Warner.
(Address) Lakeland

15 Filed SEP 19 1923 19 ROBT. R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 18, 1923, that I last saw him alive on Sept 18, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) no yrs. no mos. 12 hs ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? 6½ months.

(Signed) Raymond D. Glaun, M. D.

Sept 18, 1923 Address Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 19 1923

20 UNDERTAKER Harry N. Witz ADDRESS 1531 N Dunbard

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79240

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 Rutland Ave ST., 8 WARD)

2-FULL NAME Grace L. Humphery

(a) RESIDENCE NO. 1822 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 11, 1880

7 AGE: Years 42 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas H. Humphery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Humphery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Catherine A Boone

(Address) 1822 Rutland Ave

15 Filed SEP 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1923

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1923, to September 16, 1923.

That I last saw her alive on September 16, 1923.

And that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Hypertension

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical Examination

(Signed) Collen Castleyard M. D.

9/18 1923 (Address) 2027 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 9/19 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D79241

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 E Hoffman ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan L Eigner

(a) RESIDENCE. NO. 1502 E Hoffman ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Eigner

6 DATE OF BIRTH (month, day, and year) Dec 22 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74	74	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Freedom Pa

PARENTS

10 NAME OF FATHER John Gantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Freedom Pa

12 MAIDEN NAME OF MOTHER Lydia Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Freedom Pa

11 Informant Anna M Parlett

(Address) 302 E Hoffman

12 Filed SEP 19 1923 ROBERT N. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 1923, to Sept 18, 1923, that I last saw her alive on Sept 18, 1923, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D F Herzog MD, M. D.

9/18, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 21 1923
20 UNDERTAKER Burkler & Burkler	ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79242

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79242

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S Ann ST., 2 WARD)

2-FULL NAME Maryanna . Binkowski

(a) RESIDENCE NO. 412 S. Ann ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	—	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mateusz . Binkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Feliksa Golembiewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mateusz . Binkowski
(Address) 412 S Ann Street

Filed Sept 19 1923 . 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/18 . 1923 . to 9/18 . 1923 .

that I last saw h[illegible] alive on ... . 1923 ,

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) ... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) A. J. Krudow, M. D.

19 (Address) 918 E Fayette st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL Sep 20 1923

ADDRESS ...

20 UNDERTAKER John Maleber 1803 Bank

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79243

CERTIFICATE OF DEATH.

161-001 D79243

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ST., 7 WARD)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1923

7 AGE Years Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Johns Hopkins Hospital.

PARENTS

10 NAME OF FATHER William Henry Tolley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1923

17

I HEREBY CERTIFY, That I attended deceased from 2 PM Sept 15, 1923, to 4 PM Sept 15, 1923.

that I last saw him alive on Sept 15, 1923.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E Edmunds, M. D.

9/15, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH must be plainly filled in. See instructions on back of certificates. TION is very important.

JOHNS HOPKINS HOSPITAL SEP 15 1923

Robert F. Harrison, Commissioner Health

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79244 ✓ D79244

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Druid Hill Ave ST., 14 WARD)

2-FULL NAME Claudia Jackson

(a) RESIDENCE NO. 1626 Druid Hill Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Joseph Jackson

11 BIRTHPLACE OF FATHER (city or town) South Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Agnew

13 BIRTHPLACE OF MOTHER (city or town) South Carolina
(State or country)

14 Informant Willie Jackson
(Address) 1626 Druid Hill Ave

15 Filed Sept 21, 1923 Robert F. Garrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923 to Sept 18, 1923.

that I last saw her alive on Sept 18, 1923.

and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

9/18, 1923 (Address) 1928 Fenwal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nashville North Carolina	Sept 21 1923

20 UNDERTAKER Geo. T. A. Gibson ADDRESS 538 Lawrens Street

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79245 ✓ D79245

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Poplar Grove ST., 16 WARD)

2-FULL NAME Ernest Victor Pschundy.

(a) RESIDENCE NO. 914 Poplar Grove ST., 16 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Louise Bernard

6 DATE OF BIRTH (month, day, and year) July 22 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engraver

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1886

(c) Name of employer

9 BIRTHPLACE (city or town) Paris
(State or country) France

PARENTS

10 NAME OF FATHER Ernest Pschundy

11 BIRTHPLACE OF FATHER (city or town) Paris
(State or country) France

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) Paris
(State or country) France

14 Informant Mr. Pschundy
(Address) 914 N. Poplar Grove St

15 Filed 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to Sept 18th, 1923, that I last saw him alive on Sept 14th, 1923, and that death occurred, on the date stated above, at 3 Yrs a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. 2 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. P. Grant, M. D.

, 19 (Address) 120 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	Sept 21 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gilmor St

CAUSE OF DEATH in plain terms. No abbreviations or symptoms. See instructions on back of certificates. TION is very important.

D79246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79246

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home and Infirmary St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Bowen

(Residence in Baltimore: No. Church Home and Infirmary St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Feb. (Month) 29 (Day) 1920 (Year)

7-AGE. 3 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER. George A. Bowen

11-BIRTHPLACE OF FATHER. (State or Country). Calvert County, Maryland

12-MAIDEN NAME OF MOTHER. Pearl S. Sharp

13-BIRTHPLACE OF MOTHER. (State or Country). Talbott County, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George A. Bowen

(Address) 5 Midship Rd. Dundalk, Maryland

15-

Filed ..... 192.....

Registrar.

Robert P. Barrison,
Burial Permit Clerk

SEP 14 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second third degree burns over two thirds of the body-accidental. Clothing caught fire while playing with matches.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Pullen M. D.
(Coroner.)

9/19 1923 (Address) 5086 York Rd.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

5 Midship Rd. Dundalk, Md.

Former or usual residence 5 Midship Rd. Dundalk Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Sept 21 1923

20-UNDERTAKER. Joseph B. Cook

ADDRESS 1003 N. Bethel St.

is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79247

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bodley

(a) Residence No. Ford's Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). Gardener

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ned Bodley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Harriett ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Hospital Record

(Address).....

15- Filed 19?3 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/17/23

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 19 23 to Sept 17 19 23, that I last saw h alive on Sept 17 19 23 and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Arteria - Venous Aneurysm (Hunter's Canal Rt). Operated 3 times.

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene Rt foot & Septicemia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ? Rt foot amputated

Did an operation precede death? Yes Date of Aug 16-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) K. W. Talley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mont Auburn Cem

DATE OF BURIAL. Sept 20 19 23

20-UNDERTAKER, John H Owens

ADDRESS 538 Dolphin St

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79248 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

159-002 D79248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hammond

(a) RESIDENCE NO. ..... St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 hrs. ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, 10 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Charles Herbert Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Chas Hammond 1317 Annapolis Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Sept 19, 1923, that I last saw her alive on Sept 19, 1923, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity with cardiac insufficiency as contributing cause

(duration) 10 hrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No clinical

What test confirmed diagnosis?

(Signed) Thos A Dempsey M. D.

, 19 (Address) 857 Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 9/20/1923

20 UNDERTAKER J. Edgar Weis

ADDRESS 1317 Eighth

CAUSE OF DEATH to be plainly written. Answer all questions. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Permin J. Brugger

D79249 HEALTH DEPARTMENT—CITY OF BALTIMORE D79249

X 84

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Permin J. Brugger.

(a) RESIDENCE NO. 125 W. 24th St. ST., WARD Erie, Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 14 1891

7 AGE: Years 31 Months ..... Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Erie Pa

PARENTS

10 NAME OF FATHER Wm. Brugger.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Sophie Hesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed SEP 20 1923 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 19, 1923, that I last saw him alive on Sept 19, 1923, and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Pa

Did an operation precede death? Yes Date of Sept 17, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Exam

(Signed) Warfield M. Firor, M. D.

9/19, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Erie Pa. DATE OF BURIAL: Sept 19 1923

20 UNDERTAKER: H. C. Downing & Son ADDRESS: Erie Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79250

CERTIFICATE OF DEATH.

D79250

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO. 101

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry [redacted] Dorer

(a) RESIDENCE No. 147 N. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): June 27 1922

7 AGE: Years 1 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: babe

(b) General nature of industry, business, or establishment in which employed (or employer): 0 do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: George Dorer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Christine Kelleher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Johns Hopkins Hospital

(Address) Branch

15 Filed SEP 20 1923 ROBERT A. HUNTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Sept 18, 1923, that I last saw h alive on Sept 18, 1923, and that death occurred, on the date stated above, at 7 15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute primary (Lobar type) 7 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema - 7 ds.? Purulent pericarditis - 7 ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Wood M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Sept 20 1923

20 UNDERTAKER: E. Schumm & Son

ADDRESS 1234 Fremont Ave

CAUSE OF DEATH to plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Cristina Kraft.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79251 D79251

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N Kenwood ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cristina Kraft

(a) RESIDENCE NO. 229 N Kenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Kraft

6 DATE OF BIRTH (month, day, and year) Oct 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓

14 Informant Frieda Kraft

(Address) 229 N Kenwood Ave

15 Filed SEP 20 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May-6, 1921, to Sept-14, 1923.

that I last saw h[illegible] alive on Sept 18, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Nephritis - Senile Deg - Asthma

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremic Coma —

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) [illegible], M. D.

, 19 (Address) 125 Bolton —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Sept 21 1923

20 UNDERTAKER John Ullut

ADDRESS 6008 Orleans

CAUSE OF DEATH to plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21-001

D79252

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lesser Hazel

(a) RESIDENCE NO 1408 McElderry St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 6/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John Hazel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Grey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14
Informant John Hazel
(Address) 1403 Mc Elderry St.

15 Filed SEP 20 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Probably Streptococcus)

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paul, M. D.
(Coroner.)

9/20/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sept 20th 1923
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

Spec.—1-10-21—M&T—1500 Bks.

Edwards 700 N. Nath. 46

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79253

CERTIFICATE OF DEATH.

D79253

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Madison Ave ST., 13 WARD)

2-FULL NAME Lena A. Liddell.

(a) RESIDENCE NO. 2520 Madison ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Liddell.

6 DATE OF BIRTH (month, day, and year): Oct. 1874

7 AGE — Years: 48. Months: 11 — Days: — If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home. 13?

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Groff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mallie Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John D. Liddell. (Address) 2520 Madison ave

15 SEP 20 1923 ROBERT R. KRAUTER, Registrar [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24 1923, to Sept 19, 1923, that I last saw h[illegible] alive on Sept 19, 1923, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) ~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Louis Ebbinger, M. D.

Sept 24 1923 (Address) 700 N. Nath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 22 1923

20 UNDERTAKER: Lowebook — ADDRESS: 502 E. Fayette

CAUSE OF DEATH to be plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79254 160 D79254

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Hanover St. ST., 23 WARD)

2-FULL NAME James E. Hartline

(a) RESIDENCE NO. 1910 Hanover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin J. Hartline

11 BIRTHPLACE OF FATHER (city or town) ..... Md.
(State or country)

12 MAIDEN NAME OF MOTHER Katharine Viehmeyer

13 BIRTHPLACE OF MOTHER (city or town) ..... Md.
(State or country)

14 Informant (Address) Martin J. Hartline 1910 Hanover St.

15 FILED SEP 20 1923 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1923, to Sept 19, 1923 that I last saw h[illegible] alive on Sept 19, 1923 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Enhanitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dr. R. L. Campbell M. D.
(Signed)
Sept 20 1923 19 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Sept 19

20 UNDERTAKER J. Fenwick Colby

ADDRESS [illegible]

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79255

CERTIFICATE OF DEATH.

74-001

REGISTERED No. D79255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 Rosedale Ave (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O. Brien

(a) RESIDENCE. No. 22 Rosedal ave Hamilton St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice OBrien

6 DATE OF BIRTH (month, day, and year) Dec 30 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael OBrien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER C. Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William J OBrien (Address) 22 Rosedale ave Hamilton

15 SEP 20 1923 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 17, 1923, that I last saw h_n alive on Sept 19, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis?

(Signed) Geo. A. Long M. D.

Sept 20 1923 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Sept 22 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79256

74-001 D79256

CERTIFICATE OF DEATH.

D79256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 16 WARD)

2-FULL NAME Anna Marie Vogt

(a) RESIDENCE NO. 1005 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct 2/1864

7 AGE: 59 Years 11 Months 17 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HH

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: Peter Vogt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Maria

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Elizabeth Vogt 1005 Poplar Grove St

15 Filed SEP 20 1923, 19 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 19, 1923

that I last saw her alive on Sept 19, 1923

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Hypertension - cerebral sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1005 Poplar Grove St

Did an operation precede death? Neurohistectomy Date of Sept 13, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Seybert, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 9/22/23

20 UNDERTAKER: Geo Weber & Son — ADDRESS: 2503 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79257

CERTIFICATE OF DEATH.

31 ✓

D79257

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Edmondson Avenue and Ridge Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Esther Elizabeth Hahn

(a) Residence No. Edmondson Avenue and Ridge Road St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Singer

6-DATE OF BIRTH (month, day and year) Jan 19/1901

7-AGE.	If LESS than 1 day,
22 yrs. 7 mos. 30 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Private Secretary

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Indiana

PARENTS.

10-NAME OF FATHER. Rev. Theo. F. Hahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Missouri

12-MAIDEN NAME OF MOTHER. Elizabeth Heinrich

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14 (Informant). Rev. The F. Hahn

(Address) Edmondson Avenue & Ridge Road

15 Filed SEP 20 1923 ROBERT M. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 18/23

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to Sept 18, 1923

that I last saw h. alive on Sept 15, 1923

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Just Manifest

(Signed) Samuel Watson M. D.

, 19 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Paul's Druid Hill Park	9/21/23 19

20-UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Schaeffer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79258

D79258

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 N Paca St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Schaffer.

(a) RESIDENCE. No. 1321 N Paca St., 19 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 24 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F. Schaffer.

6 DATE OF BIRTH (month, day, and year) Sept. 17-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Grace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs Krause

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Jno F Schaffer

(Address) 1321 N Paca St

15 SEP 20 1923 RUDOLPH M. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17/23. 19

17 I HEREBY CERTIFY, That I attended deceased from 8/14/23. 19 , to 9/17/23. 19 ,

that I last saw h alive on 9/17/23. 19 ,

and that death occurred, on the date stated above, at 1145 p. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Wm F Wagner, M. D.

9/17/23 (Address) 1302 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Sept 21 19 23

20 UNDERTAKER John J Feldt — ADDRESS 700 N Fremont

CAUSE OF DEATH in plain terms. So that a ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D79259

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ D79259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

2-FULL NAME George H. Brown

(a) RESIDENCE NO. 244 S. Dallas St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Margaret White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mexico

14 Informant Municipal Hospital Records.

(Address)

15 Filed SEP 20 1923 ROBERT R. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to September 17, 1923,

that I last saw him alive on September 17, 1923,

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic aortitis

Aortic insufficiency

(duration) yrs. 7 mos (5 ds.)

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? [redacted] Lab, X-ray

(Signed) Claude B. Kram, M. D.

9-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patrick's Cemetery — DATE OF BURIAL 9/20 1923

20 UNDERTAKER Mat M Fink — ADDRESS 1737 W Balt

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79260 HEALTH DEPARTMENT—CITY OF BALTIMORE D79260

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Albert ST., 16 WARD)

2-FULL NAME John Henry Toogood

(a) RESIDENCE NO. 708 Albert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Ellen Toogood.

6 DATE OF BIRTH (month, day, and year) Nov-20-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Stone quarry.

(c) Name of employer United Quarries Co.

9 BIRTHPLACE (city or town) (State or country) Montgomery Co; Md.

PARENTS

10 NAME OF FATHER Philip Toogood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Eliza Ellen Toogood. (Address) 708 albert St

15 FILED SEP 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-19-1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1919, to Sept 19-, 1923, that I last saw him alive on Sept-18-, 1923; and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs.

(Signed) Chester Ruland, M. D.

9-19-1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem. DATE OF BURIAL Sept 21 1923

20 UNDERTAKER Samuel H Kensley ADDRESS 1128 Pine

Spec.—1-10-21—M&T—1500 Blks.

D79261 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

84 D79261

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Quarles

(a) RESIDENCE NO. 307 N. Poppleton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Quarles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed SEP 20 1923 ROBERT P. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 19 23

17 I HEREBY CERTIFY, That I attended deceased from August 16, 19 23, to Sept. 19, 19 23,

that I last saw him alive on September 18 19 23,

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Emphysema (Post Pneumonia)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Nolan M. D.

9-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakstown Va.	9-21 19 23
20 UNDERTAKER David Easton	ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79262 HEALTH DEPARTMENT—CITY OF BALTIMORE D79262

100-00

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N Pine ST., 17 WARD)

2-FULL NAME Thomas Anthony Ross

(a) RESIDENCE NO. 612 N. Pine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12-1923

7 AGE — Years: — Months: 5 Days: 9 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Willie Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Clara Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Clara Ross

(Address) 512 N. Pine St.

15 Filed SEP 20 1923, 19 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19-1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1923, to Sept 19, 1923, that I last saw him alive on Sept 19th, 1923, and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(duration) ..... yrs. ..... mos 2 ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas C Cullen M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 9-20 1923

20 UNDERTAKER: Burd Ferbert — ADDRESS: Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79263 | 129 D79263

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mt Hope Retreat ST.: 13 WARD)

2-FULL NAME Olivia S. Briggs

(a) RESIDENCE. NO. 2734 Penna. Av ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo L Briggs

6 DATE OF BIRTH (month, day, and year) Dec 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER M. Stevens

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER ~~Addison~~

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Md

14 Informant Mt Hope Friends. (Address)

15 Filed SEP 20 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Sept 19, 1923, that I last saw her alive on Sept 19, 1923, and that death occurred, on the date stated above, at 2. P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Senile Psychosis) Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia - Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Wylie Av. & Rustling Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemt	Sept 22nd 1923
20 UNDERTAKER Edelen & Co	ADDRESS W. Balto

CAUSE OF DEATH in plain terms, so that it may be understood by all. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79264 D79264

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E. Barney ST., 24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Charles Knapp.

(a) RESIDENCE NO. 505 E. Barney. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4.	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Knapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Pearl Simmonds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) James Knapp. 505 E. Barney St.

15 Filed SEP 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1923, to Sept 18, 1923, that I last saw him alive on Sept 18, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) Dr. R. L. Campbell, M. D.

Sept 18 1923 Address 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Sept. 20 1923

20 UNDERTAKER Margaret L. Flynn — ADDRESS 14 - Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79265

CERTIFICATE OF DEATH.

57 D79265

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 112 W. Hughes St. ST., 22 WARD)

2-FULL NAME Ernest Whittington. (C)

(a) RESIDENCE NO 112 W. Hughes St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Crisfield, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.
(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) Do not know.
(State or country)

14 Informant Maude Brown. (C)
(Address) 112 W. Hughes St.

15 Filed SEP 20 1923, 192 ROBERT K. KRAUTER, Clerk.
Burial Permit Issued

Remarks

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatism.

Acute dilatation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Sept. 20, 1923 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Sept 20 1923
20 UNDERTAKER	ADDRESS
C. W. Brown & Son	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79266 31 D79266

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Burgundy St. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie M. Knell

(a) RESIDENCE NO. 908 Burgundy St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) July 24, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) National Biscuit Company

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph T. Knell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Irene Price

13 BIRTHPLACE OF MOTHER (city or town) Crisfield
(State or country) Maryland

14 Informant Joseph T. Knell
(Address) 908 Burgundy St.

15 Filed ..... 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923. to Sept. 20. 1923.

that I last saw her alive on Sept. 20. 1923.

and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

— (duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) none.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam.

(Signed) Thos. Corkran, M. D.

9/26 1923 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 22 1923
20 UNDERTAKER Joseph B. Cork	ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

P 1923

Burial Permit

Spec.—1-1041—M&T—1500 Bks.

D79267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D79267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 E. Chase ST., 10 WARD)

2-FULL NAME Mary L. McHale

(a) RESIDENCE NO. 617 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 28-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Martin J. McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Della Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Della McHale

(Address) 617 E. Chase St

15 Filed SEP 20 1923, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Sept 18, 1923,

that I last saw h[illegible] alive on Sept 17, 1923,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Contributory (Secondary) Uremia

Unknown (duration) ..... yrs. ..... mos. ..... ds.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Physician & Surgeon

What test confirmed diagnosis? .....

(Signed) Geo M Dean M. D.

Sept 19, 1923 (Address) 102 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 22 1923

20 UNDERTAKER H. C. Wiedefeld & Co — ADDRESS Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79268 D79268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Kramer

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.)

5a-~~If married,~~ widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Margaret Ziet.

6-DATE OF BIRTH (month, day and year) Sept 10-1845

7-AGE. 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Francis Kramer.

11-BIRTHPLACE OF FATHER (city or town) (State or Country).....

12-MAIDEN NAME OF MOTHER. Odilia Kramer.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).....

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Filed ..... 192.... Registrar.

Robert P. Harrison

~~F 201023~~ Issued for Burial Only.

In plain terms, so that it may be properly classified, instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 9 1923

17- I HEREBY CERTIFY, That I attended deceased from No record 19.... to ..... 19.....

that I last saw h.. alive on Sept 9 1923

and that death occurred, on the date stated above, at. 8 45 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. A. Warner M. D

(Address) 1133 Valley St

Sept 20, 1923

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents DATE OF BURIAL. Sept 21, 1923

20-UNDERTAKER. H. C. Wiedefeld ADDRESS 914 Greenmt ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79269 ✓ D79269

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Homewood Av. 10 WARD)

2-FULL NAME M. Genevieve McKenna

(a) RESIDENCE No. 1204 Homewood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James J. McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary A. McKenna

(Address) 1204 Homewood ave

15 Filed Sept 20, 1923, 19

Registrar

Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Sept. 19, 1923, that I last saw him alive on Sept. 18, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray chest

(Signed) Benj. B Hayden M. D.

1923 (Address) 1216 N. Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Sept 22 1923

DATE OF BURIAL

20 UNDERTAKER K. C. Wiedefeld 914 Fremont ave

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D79270 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79270

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 W Lexington ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard L Lingerman 3 79

(a) RESIDENCE NO. 1911 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard L Lingerman Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helene V Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Bernard L Lingerman 1911 W Lexington

15 Filed , 19 Robert F. Morrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 20, 1923, that I last saw h[illegible]ive on Sept 19, 1923 and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Cranitom

(duration) ✓ yrs. ✓ mos 8 ds.

CONTRIBUTORY (Secondary) Tuberculosis (Cranium)

(duration) yrs. ✓ mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon, M. D.

9/20, 1923 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 9/21 1923

20 UNDERTAKER Forgett Funeral Fulton — ADDRESS Ft Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79271

CERTIFICATE OF DEATH.

129 D79271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Nanticoke ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Pfaff

(a) RESIDENCE. NO. 1126 Nanticoke ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced (write the word)~~
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug. 7. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Schmincke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Emma~~ Krumm.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Pfaff (Address) 1126 Nanticoke St

15 Filed ..... 19.. Robert P. Harrison Registrar

P201923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1923, to Sept. 20 1923, that I last saw her alive on Sept. 19, 1923, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) ..... M. D.

Sept 20 1923 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London PK Cemetery	9/24/23
20 UNDERTAKER	ADDRESS
Geo. Leimbach & Son.	647 N Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Uremia Interstitial nephritis

Spec—12-23-21—E.B.R.S.—400 Blks.

D79272 HEALTH DEPARTMENT—CITY OF BALTIMORE D79272

CERTIFICATE OF DEATH. 91-002

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 192 W Lewis St. 21 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F Lohman

(a) Residence No. 192 W Lewis St. 21 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick R Lohman

6-DATE OF BIRTH (month, day and year) Sept 25, 1845

7-AGE 16 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coach, Bld. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER Henry Lohman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ann Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Robt E Lohman

14- (Informant) (Address) 422 Yale Ave

15- Filed ..... 192.....

Registrar.

P 201923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 19-23

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1923 to Sept 19 1923

that I last saw him alive on Sept 19 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: Cardiac Asthenia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gen. Art. Sclerosis

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John E Schwarm M. D.

19 (Address) 11 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Sept	Sept 22 1923
20-UNDERTAKER.	ADDRESS
John B. Spence	1325 St Paul St

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79273 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79273

CERTIFICATE OF DEATH. 159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 533 N. Dukeland (St.) (WARD) 7

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaora Helen Montgomery

(a) RESIDENCE NO. 533 N. Dukeland St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	1		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank A. Montgomery

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Gott

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant Catherine Montgomery (Address) 533 N Dukeland St

15 Filed ... 19... Robert F. Garrison Registrar

Burial Permit Clerk.

P 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 19, 1923, that I last saw h[illegible] alive on Sept 19, 1923, and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH was as follows: Meningitis Otitis Media

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Coors M. D.

9/19, 1923 (Address) 418 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockwood	Sept 21st 1923
20 UNDERTAKER	ADDRESS
Leo D. Cook	Northwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79274

CERTIFICATE OF DEATH.

114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Eastern Ave. WARD) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry A. Knorr

(a) RESIDENCE NO. 1926 Eastern Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs — mos. 1 ds. How long in U. S., if of foreign birth? 56 yrs. — mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie Knorr

6 DATE OF BIRTH (month, day, and year): Sept 18th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry Knorr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Katie Knorr

(Address) 1926 Eastern Ave

15 Filed , 19 Registrar

Robert F. Harrison, Burial Permit Clerk.

P 20323

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 19, 1923, that I last saw him alive on Sept 19, 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) yrs. — mos. — ds. 18

CONTRIBUTORY (Secondary): alcoholism

(duration) yrs. — mos. 2 ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. A. Jamieson M. D.

Sept 20, 1923 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Sept 22 '23
20 UNDERTAKER	ADDRESS
Peter Nicolauszeo	Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79275

CERTIFICATE OF DEATH.

38 ✓ D79275

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 21 WARD)

2-FULL NAME John Brooks

(a) RESIDENCE NO. 703 Otterbein St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt 50 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed SEP 21 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1923

17

I HEREBY CERTIFY, That I attended deceased from September 14 1923 to Sept. 19 1923.

that I last saw him alive on Sept. 19, 1923.

and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

C.V.D. Syphilis

Right Hemiplegia 6 days

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal)

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Path.

(Signed) Claude A Nance, M. D.

9-23-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ant. Auburn

DATE OF BURIAL Sept 20 1923

20 UNDERTAKER R. L. Parham

ADDRESS 902 Leadenhall St

Spec.—1-10-21—M&T—1500 Bks.

Irene Felter

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79276

CERTIFICATE OF DEATH.

24-001

D79276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 28 WARD)

2-FULL NAME Mrs Emma Feller

(a) RESIDENCE NO. 5526 Keyserstown Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Live Annuratte

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mr John Feller

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 63 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Mr Edward Hoofgill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Irene Hartzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): 5526 Keyserstown Ave. John Feller

15 Filed SEP 21 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Sept 20 1923.

that I last saw h~~e~~r alive on Sept 20, 1923.

and that death occurred, on the date stated above, at 2:30 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy. & left side of paralysis.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. T. Hundley, Jr M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: H S Marshall

ADDRESS: 339 Hall St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79277 Cathedral & Mt Vernon Pl. 89 D79277

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Severn Apt ST., 11 WARD)

2-FULL NAME Annie E. Jackson

(a) RESIDENCE NO. The Severn Apt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 ~~Single, Married, Widowed, or Divorced~~, (write the word) Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Lloyd L. Jackson

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Lester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER ? Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Annie L. Jackson (Address) The Severn.

15 Filed SEP 21 1923 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept 19~~, 19 19, to Sept 19th, 1923,

that I last saw h alive on Sept 19th, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Art. Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C B Gamble Jr, M. D.

, 19 (Address) 24 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 9-21 1923

20 UNDERTAKER Harry W Jenkins & Bro Co

ADDRESS Mitchell & Orchard.

Spec.—1-10-21—M&T—1500 Bks.

16639 D79278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-002 D79278

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No.) ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clark

(a) RESIDENCE NO. Clark Heights ST., West Annapolis, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Clark

6 DATE OF BIRTH (month, day, and year): July 12-1860

7 AGE: Years 63 Months 2 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. Feldmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Johns Hopkins Hospital (Address)

15 Filed SEP 21 1923 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15-23, 1923, to Sept 21, 1923, that I last saw her alive on Sept 21, 1923, and that death occurred, on the date stated above, at 2:10 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 9/19/23

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md. DATE OF BURIAL: Sept 21 1923

20 UNDERTAKER: Taylor & Sons ADDRESS: Annapolis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lovie Gaitz

Spec.—1-10-21—M&T—1500 Bks.

16L290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79279

CERTIFICATE OF DEATH.

113 ✓

D79279

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5 ST., 5 WARD)

2-FULL NAME Girl Clayton

(a) RESIDENCE NO. 1405 E. Jefferson St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~John Clayton~~

6 DATE OF BIRTH (month, day, and year) Sept 18-1923

7 AGE: Years ..... Months 1 Days 27

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —0—

(c) Name of employer: —0—

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lethia Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 9 1923 19.... to Sept 14, 1923 19....

that I last saw her alive on Sept 14, 1923 19....

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. Life mos. ..... ds.

CONTRIBUTORY (Secondary) Diarrhoea (not Dysentery)

(duration) ..... yrs. 3 wks. mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) N. N. Weed, M. D.

....., 19.... (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL Sept 20 1923

20 UNDERTAKER .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D79280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79280

74-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1202 Guilford Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah R Spencer

(a) Residence No. 1202 Guilford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm T. Spencer

6-DATE OF BIRTH (month, day and year) Dec 21 1883

7-AGE. 39 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Orangeville
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo H. Chester

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Leach

13-BIRTHPLACE OF MOTHER (city or town) Columbus
(State or Country), Ohio

14- (Informant) Mrs Wm T. Spencer
(Address) 1202 Guilford ave

15- ROBERT A. KRAUTER
Filed..... 192 Registrar.

SEP 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 18/1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923 to Sept 18, 1923, that I last saw alive on Sept 17, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration)..... yrs. 8 mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Gustav Ad Olsen M. D.

Sept 19, 1923 (Address) 1120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL, Sept 21, 1923

20-UNDERTAKER, John F Denny — ADDRESS. 715 Light St

Please write plainly, as what is entered here will be printed. Consult instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001

D79281

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hosp. 4

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME John Campbell

(a) RESIDENCE NO. Dundalk Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~deceased~~ Annie Campbell

6 DATE OF BIRTH (month, day, and year) Dec 29-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired policeman

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Ret~~

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Co.

10 NAME OF FATHER Robt Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Nancy Dunlap

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co.

14 Informant University Hosp.
(Address)

15 Filed SEP 21 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1923 to Sept 29 1923,

that I last saw him alive on Sept 29 1923,

and that death occurred, on the date stated above, at 6 50 m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy 3
Bronchio-pneumonia

4 (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dundalk, Md.

Did an operation precede death? yes Date of Aug 2-23

Was there an autopsy? yes

What test confirmed diagnosis? Microscopical tests

(Signed) F. C. Rothgeb M. D.

19 (Address) Univ. Hospital Balto. Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Sept 22 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001

D79282

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3307 Guilford Avenue ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Kelly

(a) RESIDENCE NO. 3307 Guilford Avenue ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 65 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Sheehan

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Liquor Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Tessie Everhart
(Address) 3207 Guilford Avenue

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Sept 19, 1923, that I last saw him alive on Sept 19, 1923, and that death occurred, on the date stated above, at 4.22 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Hilbert F. Kellman M. D.

. 19 (Address) 6 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 9/22 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Hankofsky

HEALTH DEPARTMENT---CITY OF BALTIMORE

D79283

CERTIFICATE OF DEATH

1-001

D79283

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 427 S. Pulaski St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah Hankofsky,

(Residence in Baltimore: No. 427 S. Pulaski St.; 17 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: Unknown (Month) ..... (Day) 1 (Year)

7-AGE: 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15-

Filed SEP 21 1923 191.. ROBERT R. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September (Month) 21st (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24th, 1923, to, Sept. 21st 1923, that I saw h.e alive on Sept. 20th 1923, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) — yrs — mos. 29 ds.

Contributory (SECONDARY) Intestinal Hemorrhage

(Duration) ..... yrs ..... mos. 2 ds.

(Signed), Charles Gelb, M.D. M. D.

Sept. 21st 1923. [Address] 1111 W. Lanvale St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Kehreen Rosedale DATE OF BURIAL: 9/27 191.. 23

20-UNDERTAKER: Jack Lewis ADDRESS: 1439 E. Baltimore St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 153 Wilkens ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina E. Wagner

(a) RESIDENCE NO. 153 Wilkens ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wagner

6 DATE OF BIRTH (month, day, and year) Jan 19-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs August C. Kerbe (Address) 153 Wilkens St.

15 Filed SEP 21 1923 ROBERT R. ARNOLD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1923, to Sept 19 1923

that I last saw h alive on Sept 19, 1923,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia ?

Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Theo Koeckeritz, M. D.

(Address) 1519 W. Lombard

Sept 21, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept. 22 1923
20 UNDERTAKER	ADDRESS
George L. Schmelz & Son	1111 Park Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Guy

HEALTH DEPARTMENT CITY OF BALTIMORE

D79285

CERTIFICATE OF DEATH.

113 D79285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1091 N. Durham ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A Guy

(a) RESIDENCE NO. 1091 N. Durham ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 21 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Guy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Helen Stach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ford Guy

(Address) 109 N. Durham

15 SEP 21 1923 ROBERT R. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1923, to Sept 21, 1923.

that I last saw h[illegible] alive on Sept 20, 1923

and that death occurred, on the date stated above, at 5.25 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Convulsions 6 hr

(duration) yrs. mos. 6 hr ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical Signs

(Signed) Geo N Kellam, M. D.

9-21, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 21 1923

20 UNDERTAKER Wendell Ryall & Son

ADDRESS 378 Mmm

Information should be carefully supplied. AGE should be stated EXACTLY. If INFANT, NAME and SURNAME should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79286

CERTIFICATE OF DEATH.

162

D79286

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 N. Gay ST., 8 WARD)

2-FULL NAME Catherine E. Ecke

(a) RESIDENCE NO. 1514 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 13/23

7 AGE: Years | Months | Days: 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John H. Ecke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ina Weiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John H. Ecke Sr.

(Address): 1514 N. Gay St.

15 Filed SEP 21 1923 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Sept 21, 1923.

that I last saw h[illegible] alive on Sept 21, 1923

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

8 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lewis M. D.

9/21, 1923 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bulls Cem.

DATE OF BURIAL: 9/21 1923

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79287 | 129 D79287

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 333 S. Smallwood ST. 20 WARD)

2-FULL NAME Eveline E. Chaney

(a) RESIDENCE NO. 333 S. Smallwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis P. Chaney

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgetown, D. C.

PARENTS

10 NAME OF FATHER Joseph Temple Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown D. C.

12 MAIDEN NAME OF MOTHER Emily Ellen Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgetown D. C.

14 Informant (Address) Dennis P. Chaney 333 S. Smallwood St.

15 Filed SEP 21 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/29/25, 19 , to 9/18/23, 19 , that I last saw h— alive on 9/18/23, 19 , and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. W. Winsor, M. D.

9/19 23 (Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 21 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1001 N. Bond St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79288

CERTIFICATE OF DEATH.

78 D79288

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 Vin St. WARD 18)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Wall

(a) RESIDENCE NO. 845 Vin St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	3	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bad City
(State or country)

PARENTS

10 NAME OF FATHER Joseph Wall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Freda Rantin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed SEP 21 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions, Child has had Epilepsy since birth
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Don't Know
(duration) yrs. 1 mos. ds.

(Signed) J R [illegible], M. D.
(Coroner.)

9/21, 1923 (Address) 111 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL 9/21 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D79289

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2000 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John C. Weaver .....

(a) Residence No..... 2000 Hanover ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary A. Weaver

6-DATE OF BIRTH (month, day and year) Feb. 15 1848

7-AGE. 75 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Contractor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George H. Weaver

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary M. Essoot

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), France

11- (Informant). Mary A. Weaver

(Address)..... 2000 Hanover St.

Filed SEP 21 1923 ROBERT N. ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 20 1923

I HEREBY CERTIFY, That I attended deceased from July 15 — 1923 to Sept 20 1923

that I last saw h.. alive on Sept 9 — 1923

and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed)..... M. D.

, 19 (Address) Hutchins 1340 S. Chas

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill — DATE OF BURIAL, Sept 24 1923

20-UNDERTAKER. John F. Denny — ADDRESS 715 Light St

should be carefully supplied. ... Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79290

CERTIFICATE OF DEATH.

161-001 D79290

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 119 Cedar Ave. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby - Wm. S. Dow

(a) Residence No. 119 Cedar Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Sept. 15, 1923

7-AGE. ...yrs. ...mos. ...ds. If LESS than 1 day, 9 hrs. or ...min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER, Wm. S. Dow.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Boston Mass.

12-MAIDEN NAME OF MOTHER, Ora H. Bortner.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Maryland.

14- (Informant) Mr. Wm. S. Dow

(Address) 119 Cedar Ave.

15- Filed ... 19... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 15, 23.

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923, to Sept 15, 1923, that I last saw him alive on Sept. 15, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Miscarriage - Pregnancy advanced Six months (Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Returned at City Hosp. DATE OF BURIAL, ...19...

20-UNDERTAKER. Wm. J. Fulton, M.D. ADDRESS Municipal Hospital

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 2J~ M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79291

D79291

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Krug.

(a) RESIDENCE NO. Turner Station Balto Co ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 weeks. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Krug

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Theresa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed SEP 21 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1923, 19 , to Sept 19 , 19 23.

that I last saw him alive on Sept 19 , 19 23

and that death occurred, on the date stated above, at 9 40 A m.

The CAUSE OF DEATH* was as follows:

Dysentery (Fulminating)

(duration) yrs. mos 33 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At parents' home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Isolation of Bacillus Dysenteriæ

(Signed) Caspar Pilot M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Sept. 21, 1923

20 UNDERTAKER: Wm. Fialkowski — ADDRESS: 1615 Eastern

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-2f—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79292

CERTIFICATE OF DEATH.

100-00 D79292

D79292
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Mutzung

(a) RESIDENCE NO. Bay View Asylum ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town)? (State or country)
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed SEP 21 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 18, 19 16. to Sept. 18, 19 23.
that I last saw him alive on Sept. 17, 19 23.
and that death occurred, on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Claude A. Jones M. D.
(Address) 9-20-. 1923 Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Batnell's Cemetery — DATE OF BURIAL 9/21 1923

20 UNDERTAKER Mrs M Funk — ADDRESS 1727 W Pratt

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79293 · CERTIFICATE OF DEATH. 46 D79293

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 Oxford ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Burke

(Residence in Baltimore: No. 846 Oxford St St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH April 15, 1893
(Month) (Day) (Year)

7-AGE, 30 yrs. 5 mos. 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, William Collins

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Burke

(Address) 846 Oxford

15- Filed SEP 21 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 20, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1923, to Sept 20 1923, that I saw h[illegible] alive on Sept 19 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Catarrhal Cancer

(Duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Culbreath M. D.

Sept 20, 1923 (Address) 2039 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Va

Former or usual residence Louisa Co

19-PLACE OF BURIAL OR REMOVAL Hendrick Hall Louisa Co Va — DATE OF BURIAL, Sept 22, 1923

20-UNDERTAKER S. W. Brown & Son — ADDRESS 108 W Mulberry

B & O RR — Louisa Co. Va

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79294

CERTIFICATE OF DEATH.

74-001 D79294

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Duncan

(a) RESIDENCE NO. 1617 N. Walsh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2nd, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jno. S. Beard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) J. W. Caldwell 1007 E. Eutaw St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 19 23, to Sept 19, 19 23, that I last saw h.e alive on Sept 19, 19 23, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Phys. sign

(Signed) H. A. Schemmich, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 9/22/1923

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1938 E. Lafayette Ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

D79295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D79295

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ira B. Chester

(Residence in Baltimore: No. 1104 Brentwood Ave. St.; 35 yrs., ~~Lifetime~~ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, December 16th, 1881
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 9 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bellman
(b) General nature of industry, business, or establishment in which employed (or employer): Belvedere Hotel

9-BIRTHPLACE, (State or Country). Balto. Co. Maryland

PARENTS.

10-NAME OF FATHER, George H. Chester

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Leach

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Mary F. Chester
(Informant)
(Address) 1104 Brentwood Ave.

15- SEP 21 1923 ROBERT R. KRAUTER, Registrar.
Filed ....., 191.... Deputy Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20th 1923., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull
accidental fall from Stairs
3 days (Duration), ...yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
(Duration)....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)
9/21/23 191? (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	9/22/23., 19....

20-UNDERTAKER Chas. S. Ingerson & Son ADDRESS 11 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79296

CERTIFICATE OF DEATH.

X90 D79296

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9 WARD)

2-FULL NAME Thomas Canoles
St Joseph Hospital

(a) RESIDENCE No. 103 Patty Hill Ave. Baltimore ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Canoles.

6 DATE OF BIRTH (month, day, and year): Jan. 24 - 1888

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Decorator

(b) General nature of industry, business, or establishment in which employed (or employer): H. Chambers & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: George Canoles.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ida V. Naylor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Maria A. Canoles

(Address) 103 Patty Hill ave.

15 Filed , 19 ROBERT E. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Sept 18, 1923, that I last saw him alive on Sept 18, 1923, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Ischiorectal abscess - portal Phlebitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 103 Patty Hill Ave. - Baltimore

Did an operation precede death? Yes Date of Sept 14, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) Geo. B. Tyler, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: Sept. 21 1923.

20 UNDERTAKER: Lilly & Zile

ADDRESS: 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79297

CERTIFICATE OF DEATH.

100-001

D79297

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 E. 30. St. ST., 12 WARD)

2-FULL NAME Ephriam G. Gover

(a) RESIDENCE No. 307 E. 30. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Robb Gover

6 DATE OF BIRTH (month, day, and year): Apr. 20. 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Principal in B.C.S.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Henry J. Gover

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ann E. Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary Gover

(Address) 307 E. 30. St.

15 Filed SEP 21 1923 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1923 to Sept 19 1923.

that I last saw him alive on Sept 18 1923.

and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chandlee, M. D.

Sept 20 1923 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Sept 21 1923

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1241 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

D79298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D79298

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2016 E Lombard ST., 6 WARD)

2-FULL NAME William A. Carpenter

(a) RESIDENCE No. 2016 E. Lombard ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Nettie C. Carpenter

6 DATE OF BIRTH (month, day, and year): Aug 12 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or .... min.
68	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS
10 NAME OF FATHER: W. A. Carpenter
11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.
12 MAIDEN NAME OF MOTHER: Not Given
13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Nettie C. Carpenter
(Address): 2016 E Lombard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1919, to Sept 20, 1923, that I last saw h in alive on Sept 19, 1923, and that death occurred, on the date stated above, at 7 15 9 m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate
6

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Myocarditis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin G Krieger, M. D.

9/24 1923 (Address) 738 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Sept 22 1923

20 UNDERTAKER: Geo M. Fink & Son — ADDRESS: 811 N Wolfe

Burial Permit 0[illegible]

P 21323

maiden should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—5-19-13—M. & T.—500 Bks.

D79299

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ D79299

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths' Home Chestnut Hill ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys B. Blackson

(Residence in Baltimore: No. St. Elizabeths' Home - Chestnut Hill St.; ..... yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August (Month) 24 (Day), 1922 (Year)

7-AGE, 1 yrs. mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, City charge No information

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Mamie Blackson

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Robert P. Harrison

Filed ..... 191... Burial Permit Clerk Registrar.

SEP 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1923, to September 18 1923, that I saw h er alive on September 18 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Frank J. Boyd M. D.

Sept 20/23, 191... (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER .....

ADDRESS .....

SEP 21 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79300 ✓ D79300

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 18 Monroe St Int Mica 30 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Della Day

(Residence in Baltimore: No. 18 Monroe St.: 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Unknown ....., 1832
(Month) (Day) (Year)

7-AGE, 91 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Joseph Kelly

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nancy ~~Day~~ Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Combs

(Address) 18 Monroe St

15-

Filed ....., 191.. .....
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1923, to Sept 19 1923, that I saw her alive on Sept 19 1923, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis Valvular Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

9-24, 1923 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery

DATE OF BURIAL, Sept 24, 1923

20-UNDERTAKER Geo Agibson

ADDRESS 538 Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Delbrook)

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79301

D79301

CERTIFICATE OF DEATH.

X 179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Annie Delbrook

(a) RESIDENCE NO. 714 Redwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Delbrook

6 DATE OF BIRTH (month, day, and year) Sept 13 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Henry Gerlt

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant George Delbrook
(Address) 714 Redwood

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.)
thereon and from the evidence obtained by said find that said deceased came to his death
inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Shock from Burns
Cerebral Embolism resultant from
Shock
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Burns on body face
(duration) yrs. 4 mos. ds.

(Signed) H H Young, M. D.
(Coroner.)
9, 21, 1923 (Address) 111 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence Penna.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Sept 22 1923
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

Filed Sept 21 1923 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79302 31 D79302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 W. Pratt ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Bentgraf

(a) RESIDENCE NO. 1803 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Bentgraf

6 DATE OF BIRTH (month, day, and year): Sept 29, 1878

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 060

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Bentgraf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Kuhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Margaret Bentgraf 1803 W. Pratt

15 Filed SEP 21 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept-18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept-4, 1923, to Sept-18, 1923, that I last saw him alive on Sept-18, 1923, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James F. Schlosberger M. D.

9/21, 1923 (Address) 1729 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 22 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 157 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79303

D79303

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 22 N. Kenwood Ave St.; 6 WARD)

2-FULL NAME Richard G. Bradyhouse

(a) RESIDENCE NO. 22 N. Kenwood Ave St.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) Wife of~~ Anna H. Bradyhouse

6 DATE OF BIRTH (month, day, and year) Dec. 30 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71.	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 009

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk P. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Bradyhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Harriet Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Herbert Bradyhouse (Address) 22 N. Kenwood Ave

15 Filed SEP 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-11-23, 19 , to 9-19-, 19 23

that I last saw h~~im~~ alive on 9-19-, 19 23

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Pharyngeal Wall. (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-15-23

Was there an autopsy? no

What test confirmed ~~diagnosis~~?

(Signed) Frederick T. Hoerman M. D.

(Address) 1919 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 22 19 23

20 UNDERTAKER Mr & Mrs. J. W. Teufel & Son — ADDRESS 801 W Fayette

marion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. B & O R.R. nr Loney's Lane ~~St.~~ WARD 8)

REGISTERED NO. D79304

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23 or 25				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) unknown

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) "

(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "

(State or country)

14 Informant History from Police Dept.

(Address)

15 Filed ..... 192 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental - Head cut off - left chest crushed & evidently run overby train. Body foundby "track walker"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J S Potter, M. D.

(Coroner.)

9/17/23, 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Sept. 22 1923

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

-1-10-21—M&T—1500 Bks.

D79305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79305

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4810 Wayne Ave ST., 28 WARD)

2-FULL NAME Elizabeth Florinda Robinson

(a) RESIDENCE NO. 4810 Wayne Ave ST., 28 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 79 yrs. 4 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. F. Robinson

6 DATE OF BIRTH (month, day, and year) May-19-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Chambersburg Penna

PARENTS

10 NAME OF FATHER Wm. Linderman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chambersburg Penna

12 MAIDEN NAME OF MOTHER Sarah Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greencastle Penna

14 Informant Mrs Ida S. Saley (daughter)

(Address) 4810 Wayne Ave

15 Filed 1923 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-17 . 1923 . to 9-20 . 1923.

that I last saw h alive on 9-20 . 1923.

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

~~Coma~~ Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bright's ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Deathbed~~ Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Howe Ritchie M. D.

(Address) 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Sept 22 1923

20 UNDERTAKER STEWART & MOWEN COMPANY

(WILLIAM F. [redacted])

ADDRESS 408 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79306 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

10 D79306

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1123 Hull ST. 24 WARD)

2-FULL NAME Ellen Agnes. Nelson.

(a) RESIDENCE NO. 1123 Hull St ST., 24 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Dec. 6-1922

7 AGE: Years ..... Months 9 Days 15 If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Joseph Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Kate Herbert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Joseph Nelson 1123 Hull St

15 Filed SEP 21 1923, 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1923, to Sept 21, 1923, that I last saw her alive on Sept 21, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ovey mitutation Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) Thos. Fa Stevens., M. D.

9/21, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL 9/22 1923

20 UNDERTAKER: John F. Schaub Sons — ADDRESS 1318 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79307 16001 D79307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Hampden Ave. WARD 25)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Alfred & Lena Butcher

(a) RESIDENCE NO. 626 Hampden ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21 1923.

7 AGE

Years	Months	Days	If LESS than 1 day, 2 hrs or 60 min.
0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Alfred F Butcher

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Lena Williams

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland.

14 Informant Katie E. Butcher
(Address) 626 Hampden ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1923. to Sept. 21, 1923.
that I last saw her alive on Sept. 21, 1923.
and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. H. Machen, M. D.

9/21, 1922 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL 9/22. 1923

20 UNDERTAKER Walter Davis

ADDRESS 3307 Pant

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79308

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603. N Dallas St ST., 7 WARD)

2-FULL NAME Annie. Demery

(a) RESIDENCE NO. 603. N Dallas St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Demery

6 DATE OF BIRTH (month, day, and year): aug 10th 1884

7 AGE: Years 39 Months 1 Days 10. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): georgia

PARENTS

10 NAME OF FATHER: Ben. Copper.

11 BIRTHPLACE OF FATHER (city or town) (State or country): georgia

12 MAIDEN NAME OF MOTHER: Mettie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: John. Demery

(Address): 603 N. Dallas St.

Filed SEP 22 1923 Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923. to Sept 19, 1923.

that I last saw her alive on Sept 4, 1923,

and that death occurred, on the date stated above, at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

9-21, 1923 (Address) 120 Leisguith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eden cemetery Phila, Pa.

DATE OF BURIAL: Sept 23 1923

20 UNDERTAKER: Milton Davis 315 N

ADDRESS: Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shall sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79309

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Guilford Ave ST., 17 WARD)

2-FULL NAME Alice M. Kent

(a) RESIDENCE NO. 2416 Guilford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced. (Write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R. Kent

6 DATE OF BIRTH (month, day, and year) Apr. 12 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Orange Co. Va.
(State or country)

10 NAME OF FATHER Richard L. Broaddus

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Middleton

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mr Cureton Kent
(Address) 2416 Guilford Ave.

15 Filed SEP 27 1923 19 ... Registrar

Robert F. Hoffman, Registrar of Vital Records & Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1923 to Sept 20, 1923,
that I last saw her alive on Sept 20, 1923,
and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
Too weak for operation.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis
(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical

(Signed) John A. Abrahamson M. D.

(Address) 12-19 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. | DATE OF BURIAL Sept 23 1923

20 UNDERTAKER Wm Tickner & Sons | ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79310

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St Agnes Hospital ST.. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Hoffman

(a) RESIDENCE NO. 3223 Strickland St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~: Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Abell Hoffman.

6 DATE OF BIRTH (month, day, and year): Aug. 22, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52	—	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: George Hoffman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Martin Gallert

(Address) 3223 Strickland St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923 to Sept 19, 1923

that I last saw him alive on Sept 19, 1923

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. 8 hrs ds.

CONTRIBUTORY (Secondary) ? Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) H V Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Sept 22, 23

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Dallas St

Filed 1923

Abbott F. Harrison, Deputy Register

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pt. had no relatives in city — came in in coma — no data obtainable — died 20 hours after admission

Aurora Nephrite

Spec.—1-10-21—M&T—1500 Bks.

(Banff)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79311

CERTIFICATE OF DEATH

117 ✓ D79311

1-PLACE OF DEATH University hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Banoff

(a) RESIDENCE NO. 422 E. Lafayette St. ST., WARD U. H. 5

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ✓ ds. How long in U. S., if of foreign birth? [illegible] yrs. 3 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 6, 1904

7 AGE: Years 19 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown, Md.

PARENTS

10 NAME OF FATHER: R. F. Banoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Md

12 MAIDEN NAME OF MOTHER: Agnes K Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Williamsport Md.

14 Informant: University Hosp. (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/20/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Sept 20 1923, that I last saw him alive on Sept 19, 1923 and that death occurred, on the date stated above, at 1 00 m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis & peritonitis & Bronchio pneumonia

4 (duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

2 (duration) yrs. mos. days ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Sept 18-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) R. J. Pfeiffer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 9/24 1923

20 UNDERTAKER: Albert L Hiltz Jr 1606 N Chester St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79312

CERTIFICATE OF DEATH.

38 D79312

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Brent

(a) RESIDENCE NO. Unknown 1530 Shields Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1894 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore ?
(State or country) Md.

PARENTS

10 NAME OF FATHER [illegible] ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible] Bailey ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 19 23 to Sept. 20, 19 23 that I last saw h[illegible] alive on Sept. 20, 19 23 and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

C. N. S. Syphilis

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Tab

(Signed) Claude G Heron, M. D.

9-21-23 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cemetery DATE OF BURIAL 9-22-23 19

20 UNDERTAKER Daniel Foster ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. If less than one year, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 22 1923

[illegible] Public Records Clerk

D79313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79313

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Lockton St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Lee.

(Residence in Baltimore: No. 192 - Stockton St ... St., 5 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH. (Month) (Day) 1866 (Year)

7-AGE. 57 yrs. ~ mos. ~ ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER: Dick Knox

11-BIRTHPLACE OF FATHER, (State or Country): Knox

12-MAIDEN NAME OF MOTHER: Lucy Knox

13-BIRTHPLACE OF MOTHER, (State or Country): Knox

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Lewis

(Address) 192 Stockton St

15- Filed ... 192 ... Registrar.

Robert F. Harrison, Burial Permit Clerk.

SEP 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- Inquiry (topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Clinton Diehl M. D. (Coroner)

Sept 20th (Address) 436 Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Sept 22nd 1923

20-UNDERTAKER: Dent Carter

ADDRESS 916 Pine

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79314

CERTIFICATE OF DEATH.

113 D79314

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 N. Vincent ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Mae Ross

(a) RESIDENCE. NO. 1122 N. Vincent ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City

(State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Hasket

11 BIRTHPLACE OF FATHER (city or town) Dendron

(State or country) Va

12 MAIDEN NAME OF MOTHER Dalonia Ross

13 BIRTHPLACE OF MOTHER (city or town) Dendron

(State or country) Va

14 Informant Mrs. Alice Summers

(Address) 1122 Vincent St.

15 Filed 1923 [illegible], Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18th, 1923, to Sept. 20th, 1923, that I last saw h[illegible] alive on Sept. 20th, 1923, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. C. Bell, M. D.

, 19 (Address) 1122 N. Vincent St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	9/21 1923
20 UNDERTAKER [illegible]	ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P221523

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Agustín Enlenda

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79315 D79315

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1265 Haubert ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Flynn

(a) RESIDENCE NO. 1265 Haubert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. J. Flynn

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 56 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Bart McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann McGeever

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Thos J. Flynn

(Address): 1265 Haubert St.

15 Filed: SEP 21 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1917, to Sept. 20, 1923, that I last saw her alive on Sept 19, 1923, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma of Intestines

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1917

Was there an autopsy? no

What test confirmed diagnosis? Typical Examination

(Signed) J. Edward Norris, M. D.

9/21, 1923 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: Margaret L. Flynn — ADDRESS: 1422 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79316

CERTIFICATE OF DEATH.

164 D79316

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 109 Mapel ave. ST., 28 WARD)

2-FULL NAME John Bieberich

(a) RESIDENCE NO. 109 Mapel ave. ST., 28 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary Bieberich

6 DATE OF BIRTH (month, day, and year) May 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Hair Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Hair Factory

(c) Name of employer Willson Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christopher Bieberich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mart Kusco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John W. Bieberich

(Address) 109 Mapel ave Wakefield

15 Filed SEP 27 1923, 19.....

Registrar [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Sept 20, 1923, that I last saw h in alive on Sept 19, 1923, and that death occurred, on the date stated above, at 7.55 p. m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Register Dill M. D.

9/27 1923 (Address) 1733 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Sept 24 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 4038 Wolfe St

A. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN'S statement should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D79317

REGISTERED No. 18/23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Unknown ST., Body was found in Greenmount Cemetery on Sept 16/23 by John Folble employee. M. by nr main ent. WARD 9

2-FULL NAME Unknown Male Child

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Probably colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 2	hrs		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant
(Address)

15 Filed SEP 22 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmrrhage- probably caused at birth.(autopsy done by Dr. Maldeis & he reports that child was born alive but thinks no murder was committed, death was from natura causes.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Ford, M. D.
(Coroner.)

9/20/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL SEP 22 1923, 192

20 UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

SEP 22 1923

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79318

CERTIFICATE OF DEATH.

D79318

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 543 W Lafayette Ave Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Peggy J. Sterling

(a) Residence No. 543 W Lafayette Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	Col	—

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 12 23

7-AGE. — yrs. 8 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Andrew Sterling

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Rose Richards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant)..... Ethel Sterling

(Address)..... 543 W. Lafayette Ave.

15- Filed..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 20/23

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1923, to Sept. 20, 1923, that I last saw h.r alive on Sept. 20, 1923, and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible] M. D.

9/21, 1923 (Address) 1016 Eamondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Zion	Sept 23 19
20-UNDERTAKER.	ADDRESS
Daniel F. Dennison	Pratt

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79319

D79319

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1717 Park Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Millholland

(a) RESIDENCE. No. 1717 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Mullen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Baxter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Helen M Willey
(Address) 1717 Park Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to Sept 20, 1923, that I last saw her alive on Sept 12, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm F. Watson, M. D.

Sept 21, 1923 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Sept 24 1923

20 UNDERTAKER Geo G Smith

ADDRESS Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho... stat... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement o... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S—400 Bks.

D79320 HEALTH DEPARTMENT—CITY OF BALTIMORE

D79320

CERTIFICATE OF DEATH.

118-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Albert Williams

(a) Residence No... 5-35- D Gilmor St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Williams

6-DATE OF BIRTH (month, day and year) 1889

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or. mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) Laundryman.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Jamaica
(State or Country),

PARENTS.

10-NAME OF FATHER, Edward Williams

11-BIRTHPLACE OF FATHER (city or town)..... ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..... ?
(State or Country),

11- (Informant)..... Hospital Records.

(Address).....

13-

Filed..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/18/23

17- I HEREBY CERTIFY, That I attended deceased from 9/17/23, 19..... to 9/18/23, 19.....

That I last saw him alive on 9/18/23, 19.....

and that death occurred, on the date stated above, at 5-40 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (?)

?

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) K. W. Hillery M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Asbury Cemetery — DATE OF BURIAL, Sept-22, 1923

20-UNDERTAKER. Wm R A Elliott — ADDRESS 1725- Ashland Ave

See instructions on back of certificates.

PHYSICIANS should be careful, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79321

CERTIFICATE OF DEATH.

31 D79321

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N Gilmor ST., 19 WARD)

2-FULL NAME Beatrice Brett Burrell

(a) RESIDENCE NO. 318 N Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-11-1904

7 AGE — Years: 18 — Months: 10 — Days: 8 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): Student

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Wm Burrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mecklenburg Co Va

12 MAIDEN NAME OF MOTHER: Martha Tolley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Foster Va

14 Informant: John Burrell Father

(Address) 1633 East Monument St

15 Filed ..... 19 ..... Registrar

EP 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 19, 1923, that I last saw h[illegible] alive on Sept 18, 1923, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ND

Did an operation precede death? ND Date of .....

Was there an autopsy? ND

What test confirmed diagnosis? Physical Exam

(Signed) Walter D Lowery, M. D.

, 19 (Address) 6 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Sept 23 1923

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1725 Asbland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79322

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby White

(a) RESIDENCE NO. Cella Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johns Hopkins Hospital.

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Pauline Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed SEP 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Sept 21, 1923, that I last saw him alive on Sept 21, 1923, and that death occurred, on the date stated above, at 6 00 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

9/21, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmell — DATE OF BURIAL Sept 22 23

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bro

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79323 + 45

CERTIFICATE OF DEATH.

REGISTERED NO. D79323

1-PLACE OF DEATH It & Kelly Hosp.

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles A. Conti

(a) RESIDENCE NO. Lebanon N. H. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Speranza Conti

6 DATE OF BIRTH (month, day, and year) Sept 20 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orsa Italy

PARENTS

10 NAME OF FATHER John Leonti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Speranza Leonti (Address) Lebanon N. H.

15 Filed SEP 23 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1923, to Sept. 22, 1923, that I last saw him alive on Sept 22, 1923, and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows: Intestinal obstruction

(duration) ..... yrs. ..... mos ✓ ds.

CONTRIBUTORY (Secondary) Carcinoma Rectum

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Sept 14-1923

Was there an autopsy? Yes Pathological Dept.

What test confirmed diagnosis?

(Signed) Nelson Morris Jr. M. D.

Sept 23 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lebanon New Hampshire	Sept 23 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79324

CERTIFICATE OF DEATH.

188-003

D79324

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edward H. J. Stesch

(Residence in Baltimore: No. 305 E. Lafayette Ave. St.; 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. January (Month) 3 (Day) 1846 (Year)

7-AGE. 77 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchmaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... and Jeweler

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER. Julius Stesch

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Reed Stesch

(Address) 2900 Clifton Ave.

15-

Filed ..... 192.....

ROBERT E. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH: was as follows*

Concussion of Brain
(Automobile accident)

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

9/20 192 3 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State...70 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

305 E. Lafayette Ave.
Former or usual residence Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Sept 22 1923
20-UNDERTAKER. Joseph B Cook	ADDRESS 1003 N Dallas St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79325 ✓ D79325

D79325

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Evesham Avenue ST., 27 WARD)

2-FULL NAME William Amos Gardiner

(a) RESIDENCE NO. 427 Evesham Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances I. Cole

6 DATE OF BIRTH (month, day, and year) July 31, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant - Keeker

(b) General nature of industry, business, or establishment in which employed (or employer) Firm of Kline &

(c) Name of employer Gardiner 08

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER ------- Gardiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Emma J. Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Mrs. Frances I. Gardiner 427 Evesham Avenue

15 Filed SEP 23 1923 ROBERT A. KRAUL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) September 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1923, to Sept 20th, 1923, that I last saw him alive on Sept 20th, 1923, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Frederick Stough M.D. M. D.

9/21/23 (Address) 4012 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 9/24 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 19326

D79326

CERTIFICATE OF DEATH.

Registered No. 44

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Zominski

(a) Residence No. 6 Preston & Bailey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-~~If married,~~ widowed, ~~or divorced,~~ ~~HUSBAND of (or) WIFE of~~ of Michael Zominski

6-DATE OF BIRTH (month, day and year) 12 Jan 1843

7-AGE. 80 yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Madelinski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). —

12-MAIDEN NAME OF MOTHER. Anna Terondka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant). Sister Florence

(Address). Preston & Bailey Sts

15- Filed SEP 23 1923 ROBERT A. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 22/23

17- I HEREBY CERTIFY, That I attended deceased from 1923 to Sept 22 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) a

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Sept (Signed) F. A. Warner, M. D

22 1923 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus

DATE OF BURIAL. Sept 25. 1923

20-UNDERTAKER. William Fiallowski

ADDRESS 1618 Eastern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79327

89 D79327

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Notre Dame of Maryland

CITY OF BALTIMORE: (No. Charles St. Ave. ST., 27 WARD)

2-FULL NAME Mary Dismas Himmelgarn

(a) RESIDENCE NO. Notre Dame of ST. Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 1 mos. ds. How long in U. S., if of foreign birth? 54 yrs. 60 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or (1) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	79	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic work

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Himmelgarn

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Mariana Heid 9/12

13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Germany

14 Informant Sister M. Philemon
(Address) Charles St Ave, Balto. Md

15 Filed SEP 23 1923 HUBERT R. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16. 1923. to Sept 21. 1923. that I last saw h alive on Sept 20, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

19 23 (Address) 47 W Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govens Town (Penna) Cem

DATE OF BURIAL Sept 24 1923

20 UNDERTAKER Frank A. Fink

ADDRESS 915 N Gay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79328 188-001 D79328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 E. Federal St., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Ireland

(a) RESIDENCE No. 420 Federal St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 9 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	15 days		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Robt Johnson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER M. Sawrel

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Thos Ireland

(Address) 420 Federal

15 Filed SEP 23 1923 HUBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract - Skull. accidentally
Fract by Auto Engine
Cerebral Hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Reik, M. D.

(Coroner.)

Sept 23, 192 3 (Address) 1659 Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn DATE OF BURIAL Sept 23 192 3

20 UNDERTAKER Saml J. Hansler ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79329

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Demby

(a) Residence No. 513 Greenwood (Queenwillow) St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1891

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Albert Squirrel

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Mamie Hall

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 23 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1923, to Sept. 21, 1923

that I last saw her alive on Sept. 21, 1923

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D

9-21, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Bel Union Cem	9-24, 1923
20-UNDERTAKER,	ADDRESS 916
Saml Foster	Bal

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79330 ✓ D79330

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1025 E Front St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barnes

(a) RESIDENCE. No. 1025 E Front St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md

PARENTS

10 NAME OF FATHER Robert Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER X Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Morris
(Address) 1025 E. Front St

15 Filed SEP 23 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 22, 1923, that I last saw h[illegible] alive on Sept 17, 1923, and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

Ind Acute (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C Edward Fisher, M. D.

9-22, 1923 Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Lawn	9-24 1923
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79331

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79331

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 576 N Vincent ST., 19 WARD)

2-FULL NAME Lousia Jones

(a) RESIDENCE NO. 576 N Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Jones

6 DATE OF BIRTH (month, day, and year) Dec. 23, 186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Chas. Belt

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Hannah [illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mary L. [illegible] Rus
(Address) 576 N Vincent

15 Filed SEP 23 1923 ROBERT B. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, to Sept 20, 1923, that I last saw h[illegible] alive on Sept 20, 1923, and that death occurred, on the date stated above, at 6.04 a. m.

The CAUSE OF DEATH was as follows: Chronic Nephritis

(duration) ..... yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter J. Jones, M. D.

19 (Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 23-23

20 UNDERTAKER John H Todhunter

ADDRESS 1027 Druid Hill Ave

N. B.—SIMPLE LEGIBLE HANDWRITING IN THIS DATA IS ESSENTIAL TO ACCURATE RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Noisette

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-004 D79332

D79332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

2-FULL NAME Frederick Noisette

(a) RESIDENCE NO 924 Bolton St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Hollon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Hollon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry Noisette
(Address) 924 Bolton St

15 SEP 23 1923 ROBERT A. KRAUTH
Filed ..... 192 ..... Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Streptococcal)

Endocarditis (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Following Sore Throat (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Ruby, (Coroner.) ....., M. D.

Sept 22, 192 3 (Address) 1643 E Baltimore

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) Born here

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Sept 25 192 3

20 UNDERTAKER Jos. T. H. Roberts

ADDRESS 1411 Fulton Ave

FOR IS very important. See instructions on back of certificate.

D79333

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

(See affadavit over) 86-001 ✓

D79333

1 PLACE OF DEATH CITY OF BALTIMORE (No. 1820 Eutaw Place WARD 5)

REGISTERED No.

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Max Lansburgh

(Residence in Baltimore: No. 2213 Eutaw Pl St. 65 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY—WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

MARRIED, WIDOWED, DIVORCED (Write the word): Married

6 DATE OF BIRTH: March (Month) 19 (Day) 1859 (Year) 1858

7 AGE: 64 yrs. 6 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk-Notions
(b) General nature of industry, business, or establishment in which employed (or employer): Nachelor Co.

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Mordecai Lansburgh

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Lansburgh

(Address) 918 Chaundey Ave

15

Filed SEP 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 22 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Sept 22 1923

that I saw h[illegible] alive on Sept 22, 1923

and that death occurred, on the date stated above, at 1.23 P m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcus Medea - 2½ mo.

Septicaemia (Duration) yrs. mos. 10 ds

Contributory (SECONDARY) Acute Lepto Meningitis (Duration) yrs. mos. 2½ ds.

(Signed) Ezra Cohen M. D.

Sept 23, 1923 (Address) 1820 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Friendship Ex.

DATE OF BURIAL: 9/23/1923

20 UNDERTAKER: David Sondheim

ADDRESS: 115-20 W. Royal Ave

OCT 2 - 1923

Personally appeared before me this 2nd day
of October. 1923. Mr Fred Laushugh.

Mr Fred Laushugh. who made
oath Laushugh. Mrs Laushugh.
for of Mr Mary Laushugh
Affidavit that the age given on Death
Certificate #8. 79 33, is incorrect
Should read. March 19th 1868.

Fred Laushugh

Sworn & Subscribed
before me
this 2nd day
of October
1923.

George H. Gr
Notary Public

arcinoma, *Sarcoma*, etc., "Cancer" is less definite; malignant neoplasms); *ronic valvular heart dis- ritis*, etc. The contribu- nt) affection need not be mple: *Measles* (disease *opneumonia* (secondary), mptoms or terminal con- Anæmia" merely sympto- "Coma," "Convulsions," enile," etc.), "Dropsy," e," "Hæmorrhage," "In- ge," "Shock," "Uræmia," nite disease can be ascer- ualify all diseases result- iage, as "PUERPERAL *sep- nitis*," etc. State cause was undertaken. For OF INJURY and qualify as DAL, or as *probably* such, nitely. Examples: *Acci- railway train — accident; micide; Poisoned by car-* The nature of the injury, sequences (e. g., *sepsis*, the head of "Contribu-

for additional informa- lowing diseases, without of death:

ningitis, *Phlebitis*,
carriage, *Pyaemia*,
osis, *Septicaemia*,
tonitis, *Tetanus*,

ed to a Coroner: iminal negligence pos- *micides*, *Abortions* (*if* rectly or indirectly due

Spec.—1-10-21—M&T—1500 Blks.

D79334

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

23 D79334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Julia Kahn

(a) RESIDENCE NO. 2526 Brookfield Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Mark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hannah Rothenstein (Address) 426 Green St

15 Filed SEP 23 1923, 19 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 23, 1923, that I last saw her alive on Sept 23, 1923, and that death occurred, on the date stated above, at 1.05 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica.

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac failure & pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. T. Hunnally Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew | DATE OF BURIAL Sept 24 1923

20 UNDERTAKER J. Ahrens & Co | ADDRESS 16 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Eva B. Kittrell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79335 ✓ D79335

D79335

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Appelton St. Eva Bell 16 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. William Sheppard Kittrell

(Residence in Baltimore: No. 808 Appelton St.; 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Dec. 1, 1869 (Month) (Day) (Year)

7-AGE, 53 yrs. 9 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Foxboro - Mass.

PARENTS.

10-NAME OF FATHER, James F. Forman

11-BIRTHPLACE OF FATHER (State or Country), Foxboro - Mass

12-MAIDEN NAME OF MOTHER Mary Jaurs

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William S. Kittrell

(Address) 808 Appelton St.

15-

SEP 23 1923 ROBERT B. KHAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1923, to Sept 22 1923, that I saw her alive on Sept 21 1923, and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema lungs

(Duration) yrs. 1 mos. ds.

(Signed) Jno. L. Todd M. D.

9/22, 1923 (Address) 735 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemt

DATE OF BURIAL, Sept 24, 1923

20-UNDERTAKER Artisan Hse

ADDRESS 123 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79336

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D79336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 913 W. 37 ST., 13 WARD)

2-FULL NAME James. A. Meade

(a) RESIDENCE NO. 913 W. 37 ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Sarah A Meade

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen McMahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James Meade

(Address) 3640 Hickory Ave

15 Filed SEP 23 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to Sept 21, 1923,

that I last saw h alive on Sept 21, 1923,

and that death occurred, on the date stated above, at 3. A.M. P.M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart with Dilatation.

Duration—Interval yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic congestion of lungs (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R B Norment M. D.

9.22. 1923 (Address) 3343 Chelsea Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Govan — DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: A S Marshall — ADDRESS: 353 Fall Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Marll.

D79337

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 118-001 D79337

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kathryn Marll

(a) RESIDENCE NO. Joppa Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Marll

6 DATE OF BIRTH (month, day, and year) Mar 15, 1860

7 AGE: Years 63. Months 6 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs K Marll Joppa Md.

15 Filed 19 ADOLF A. KRAUTH (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21. 19 to Jan 23 19.

that I last saw h alive on Jan 23 19,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Cardiac failure

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senility, Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

What test confirmed diagnosis? Clinical

(Signed) W. A. Tompkins, M. D.

19 (Address) 1417 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stephens — DATE OF BURIAL: Jan 26 1923

20 UNDERTAKER: Howard R. McComas — ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D79338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79338

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Oak ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Leary

(a) RESIDENCE No. 2128 Oak St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15th, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	65	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Art Students Club

(c) Name of employer Art Students Club Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. H. Leary

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Nickson

13 BIRTHPLACE OF MOTHER (city or town) Harrisburg (State or country) Penna

14 Informant Edmund Leary

(Address) 2128 Oak St. Baltimore, Md.

15 Filed SEP 23 1923 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to Sept 22, 1923, that I last saw h[illegible] alive on Sept 22, 1923, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with hypertension

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic - Hist. Lab.

(Signed) [illegible], M. D.

Sept. 23 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Sept 25 1923

20 UNDERTAKER A. M. Jenkins & Son Co

ADDRESS Orchard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79339

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D79339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2525 Shirley Av ST., 15 WARD)

2-FULL NAME Jacob Gumenick

(a) RESIDENCE NO. 2525 Shirley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Gumenick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Mollin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed SEP 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept. 22, 1923, that I last saw h in alive on Sept. 22, 1923 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Auscultation etc.

(Signed) Herman J. Dorf, M. D.

, 19 (Address) 3730 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rozedell

DATE OF BURIAL 9/23 19 23

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79340

CERTIFICATE OF DEATH.

117 X

D79340 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard N. Elliott

(a) Residence No. Taneytown Md St., Ward

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 days ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1920

7-AGE. 3 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George B. Elliott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mabel Hunter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14- (Informant) Hospital Records

(Address)

Filed SEP 24 1923 ROBERT B. ROUTSON, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9/23/23

17- I HEREBY CERTIFY, That I attended deceased from 9/18/23, 19 to 9/23/23, 19

that I last saw him alive on 9/22/23, 19

and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis (Ruptured)

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Peritonitis - Intestinal Obstruction

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Operated and died

Did an operation precede death? Yes. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. W. Talley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Taneytown Md — DATE OF BURIAL, Sept 25, 1923

20-UNDERTAKER, R. M. Routson — ADDRESS 223 N Howard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79341

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1039 N. Calvert St. 11 X 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. John A. Williams

(Residence in Baltimore: No. none in Baltimore, St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) Unknown

6-DATE OF BIRTH, ... 1.....
(Month) (Day) (Year)

7-AGE, 51 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Person Co., N. C.

PARENTS:

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER, (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER, (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry R. Bush

(Address) Greensboro, N. C.

15- SEP 24 192 ROBERT B. KRAUTER, Registrar.
Filed ..... 192.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23 192 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest,
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest,
(Inquest, autopsy or inquiry.) and that said deceased came to Natural death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Case years duration Cutting
right femoral artery
Short while (Duration) Suicidal ds.

CONTRIBUTORY
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Sept 23 192 7 (Address) 1029 Park

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. 8 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Greensboro N. C.

19-PLACE OF BURIAL OR REMOVAL: Greensboro, N. C. DATE OF BURIAL: Sept 23 1927

20-UNDERTAKER: Henry W. Means & Son ADDRESS 805 N. Calvert St

Via Penn R.R. Escort Harry Bush - Greensboro, N. C.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 X 154-003

D79342

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Cor. Lombard & Green ST.,(or) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia May Coffey

(a) RESIDENCE NO. Waynesboro, Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 (Single), Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5 weeks			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Waynesboro, Pa.
(State or country)

PARENTS

10 NAME OF FATHER John Coffey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Hess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Hospital Records.
(Address)

15 Filed , 19 ROBERT B. KRAUTER, Registrar

SEP 24 192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.23 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21st, 1923, to Sept 23rd, 1923, that I last saw h[illegible] alive on Sept. 23rd, 1923, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Hare-lip, cleft palate

(duration) yrs. mos 5 weeks ds.

CONTRIBUTORY (Secondary) Post-operative Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 22/923.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings.

(Signed) James D. White, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waynesboro Pa

DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: Harry H. Witzke

ADDRESS: 153 W. Lombard St

Spec.—1-10-21—M&T—1500 Bks.

Ulysses S. Craig

D79343 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D79343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 William ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ulysses S. Craig.

(a) RESIDENCE No. 1524 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Craig.

6 DATE OF BIRTH (month, day, and year) May 8 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas. Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Couch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary A. Craig (Address) 1524 William St

15 Filed SEP 24 1923 19 Registrar ROBERT E. KRANTZ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1923, to Sept 21, 1923, that I last saw h alive on Sept 20, 1923, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation / Heart

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Malaria

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) C Mitchell, M. D.

Sept 23, 1923 (Address) 1224 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	9-24 1923
20 UNDERTAKER	ADDRESS
Ehb Hasle	115 E Mad St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79344

CERTIFICATE OF DEATH.

92

D79344

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

2-FULL NAME Mary Hensler

(a) RESIDENCE No. 3219 Foster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Operator

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed SEP 24 1923 RUDOLF E. KRAUER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from September 3 19 23, to September 21 19 23,

that I last saw her alive on September 21 19 23,

and that death occurred, on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion (Hypostatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombophlebitis - Left femoral

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Fulton, M. D.

9-22-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dodd's Cemetery, Inc	Sept 24 1923
20 UNDERTAKER Robt Tolmer	ADDRESS 1X2 Pulaski Hwy

Cor.—1-12-23—M&T—100 Bks.

D79345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1015 W. Lanvale St., 16 WARD)

2-FULL NAME Laura W. Kimberly

(a) RESIDENCE No 1015 W. Lanvale St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Divorced

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. Kimberly

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired (Home Duties)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Stephen Wain

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary W. Kimberly
(Address) 1015 W. Lanvale St.

15 Filed SEP 24 1923 Registrar ROWLAY R. KRAUTER Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Sept. 22 1923 (Address) 2502 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Sept. 24, 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

D79346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D79346

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 W. Lanvale ST. 16 WARD)

(If death occurred in a hospital or institution, give NAME instead of street and number.)

2-FULL NAME Narcissa N. Hodgdon

(a) RESIDENCE No. 1017 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Moses~~ Moses C. Hodgdon

6 DATE OF BIRTH (month, day, and year): Mch 4, 1851

7 AGE: Years 72 Months 6 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Benj. Caughy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Ellen R. Bannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Ann R. Herring 1017 W. Lanvale St

15 Filed ..., 19... Registrar: SEP 24 1923 ROBERT B. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from September 17, 1923, to Sept. 21, 1923, that I last saw h[illegible] alive on Sept. 21, 1923, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Heart Sinus Symptom

(Signed) Charles Lieb, M. D.

Sept 24 1923 (Address) 111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79347 ✓ D79347

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Howard A. Kelly Hospital (ST.) (WARD)

2-FULL NAME Mr. William M. Burton

(a) RESIDENCE No. 319 N. Carrollton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Hattie B.

6 DATE OF BIRTH (month, day, and year) 10/17/1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston
(State or country) Mass

PARENTS

10 NAME OF FATHER John Burton

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass.

12 MAIDEN NAME OF MOTHER ? Mills

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) England

14 Informant Louis Schaeffer
(Address) 634 N. Carey St.

15 Filed ..., 19 ..... Registrar

SEP 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1923, to Sept 21st, 1923, that I last saw him alive on Sept 21st, 1923, and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Peritoneal Carcinomatosis

(duration) ..... yrs. 9 mos ? ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Guy A. Cromwell M. D.

9/21, 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 9/25/1923

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 N. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79348

CERTIFICATE OF DEATH.

179 D79348

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 48 S. Fulton ave. ST., 19 WARD)

2-FULL NAME Roderick C. N. Hard

(a) RESIDENCE NO. 48 S. Fulton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phoebe C. Hard

6 DATE OF BIRTH (month, day, and year) Mch 27. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpet

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. R. Hard

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Weaver

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant D. C. Hard Jr

(Address) 48 S. Fulton ave

15 Filed SEP 24 1923 19 Registrar Robert J. Krauter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept 21, 1923, that I last saw him alive on Sept 21, 1923, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia —

a Myocardial insufficiency

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) M. Bowman Stone M. D.

9/22, 1923 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 24 1923

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Fayette St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79349 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74007 D79349

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1225 Mt. Royal av. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Ella V. Alvey (ALVEY)

(a) Residence No. 1225 Mt. Royal av. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 27 1846

7-AGE. 77 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Lionel Schofield

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Prince Geo Co Md.

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). unknown

14- (Informant) Ella Alvey

(Address) 1312 Oakmont Ave

15- Filed SEP 24 1923 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 23/23

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1923 to Sept 23 1923 that I last saw h. alive on Sept 22 1923 and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) L. M. Lemmerin M. D

(Address) 426 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem

DATE OF BURIAL. Sept 25 1923

20-UNDERTAKER. Geo. J. Lind

ADDRESS 1121 Madison Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79350

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79350

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5009 Beaufort Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Rhodes

(a) Residence No. 5009 Beaufort Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 9 - 1897

7-AGE. 26 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph N Rhodes

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Rosalie Hardesty

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country), Md

14- (Informant) W. Edgar Rhodes

(Address) 3502 Fairview Ave

15- Filed SEP 24 1923 ROBERT E. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 22 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 20 1923 to Sept. 19 1923

that I last saw h[illegible] alive on Sept. 20 1923

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacilli

(Signed) Charles F. Gentzkow M. D

Sept 22 1923 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL, Sept 24, 1923

20-UNDERTAKER, George Smith

ADDRESS Holliday St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 29 D79351

City of BALTIMORE: (No. 624 O Paca St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Caroline M Wanken

(a) Residence No... 624 O Paca St.,... Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Wanken

6-DATE OF BIRTH (month, day and year): Aug 14 844

7-AGE: 79 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Louis Wieland

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Mrs. Alice F. Kuklop

(Address) 624 O Paca St

15- Filed SEP 24 1923 ROBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 22 1923

17- I HEREBY CERTIFY, That I attended deceased from July 22 1923 to Sept 22 1923

that I last saw h.r alive on Sept 22 1923

and that death occurred, on the date stated above, at 2.25 p m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Tests

(Signed) J M Dalchert M. D.

Sept 23 1923 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Sept. 25 1923

20-UNDERTAKER: H Keemann

ADDRESS: 324 N Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79352

REGISTERED NO. 11-02 D79352

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Laurens St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. Bean

(a) RESIDENCE NO. 1107 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Schooly

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	16	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schooly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jack R Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co.

12 MAIDEN NAME OF MOTHER Mattie Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nathan Co Va

14 Informant Jack R Bean
(Address) 1107 Laurens St

15 Filed SEP 24 1923 ROBERT B. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Sept 22, 1923, that I last saw h. alive on Sept 22, 1923, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Contemarr M. D.

Sept 23 1923 (Address) 20 E N Caldwell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Sept 25 1923
20 UNDERTAKER	ADDRESS
Thomas E Wright	Edgar Cor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 218 E. 21st (St.) (Ward) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy B. Harman

(a) RESIDENCE. No. 2 P E. 21st St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 16, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Harman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louisa B. Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miss E. Corinne Harman (Address) 218 E. 21st St

15 Filed SEP 24 1923, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEP 22 1923

17

I HEREBY CERTIFY, That I attended deceased from August 23, 1923, to Sept. 22, 1923,

that I last saw her alive on Sept. 22, 1923,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Infection of Gall Bladder

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Austin F. Robinson M. D.

SEP 24 1923 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: SEP 25 1923

20 UNDERTAKER: Geo W. Little — ADDRESS: 2200 Monument

Cor.—1-12-23—M&T—100 Bks.

D79354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79354

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 So. Caroline ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philipp Thornhill

(a) RESIDENCE NO 313 So. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dept
(Address) Eastern Dist

15 Filed SEP 24 1923, 192 ROBERT B. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. D. Horton, M. D. (Coroner.)

Sept 20 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sept 24 1923
20 UNDERTAKER	ADDRESS
Jos. T. H. Rochester	1113 Jefferson St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D79355

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 18 WARD)

2-FULL NAME Annie ~~Lithuanian~~ Schenski

(a) RESIDENCE NO. 808 W. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ben Schenskas

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 30; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): 808 W. Pratt St.

15 Filed Sept 25 1923 HUBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 at 8.30 A.M. 1923, to Sept 22, 9.05 P.M. 1923.

that I last saw h e alive on Sept 22, 1923,

and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Fungus Poisoning (Mushroom)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia

Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Elmer Hall, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 9-25 1923

20 UNDERTAKER: Ch. B. Kuchauskas — ADDRESS: 637 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D79356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79356

CERTIFICATE OF DEATH.

Registered No. 16 47

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 Longwood St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Russell

(a) Residence No. 1126 Longwood St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) January 22nd 1859

7-AGE. 64 yrs. 8 mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer Baltimore City

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. John Russell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER. Sarah A Hart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Mrs Lillian R. Coberth

(Address) 1126 Longwood St.

15- Filed SEP 24 1923 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 22nd 1923

17- "I HEREBY CERTIFY, That I attended deceased from April 15 1923 to Sept 22 1923 that I last saw h. alive on Sept 22 1923 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Rt)

(Duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 7yrs ago

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Exam

(Signed) Jos L Zuhlke, M. D.

Sept 24 1923 (Address) 1107 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Sept 24th 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Dallas

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79357

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Continental Can Co Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Stobl

(Residence in Baltimore: No. 3167 Elmora St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Mar 1 [illegible] 1.....
(Month) (Day) (Year)

7-AGE. 67 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Geo Stobel

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna Seamon

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stobel

(Address) 3167 Elmora Ave

15-

Filed SEP 24 1923 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22 192.3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo Edwin Radcliffe M. D.
(Coroner)

Sept 24 1923 (Address) 1436 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs. 6 mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Schwartz's Cem — DATE OF BURIAL. Sept 25. 1923

20-UNDERTAKER. John Ulrich — ADDRESS 2008 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79358

CERTIFICATE OF DEATH.

12 2 D79358

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 298 Delaware ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredrick Valentin

(a) RESIDENCE NO. 714 Greenmount ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fredericka Valentin

6 DATE OF BIRTH (month, day, and year): Oct 23 - 1860

7 AGE — Years: 62 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchmaker

(b) General nature of Industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Valentin

(Address): 722 Dallas St

15 Filed SEP 24 1923, 19.. Registrar ROBERT R. KRAUTER, CHIEF CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Sept 21, 1923.

that I last saw him alive on Sept 21, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mytral Regurgitation

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Cirhosis of Liver.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav A. Fritz, M. D.

9/23, 1923 (Address) Overlea.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 9/24 1923

20 UNDERTAKER: J. J. Moran — ADDRESS 3000 E Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

not alcoholic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79359

CERTIFICATE OF DEATH.

114 ✓ D79359

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Eastern ave. ST., 1 WARD)

2-FULL NAME Joseph P. French

(a) RESIDENCE NO. 2809 Eastern ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 22-1921

7 AGE — Years: 2 — Months: 6 — Days: — If LESS than 1 day, hrs or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm. J. French

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Caroline Marll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Wm. Marll 2809 Eastern ave

15 Filed SEP 24 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21 19 23

17 I HEREBY CERTIFY, That I attended deceased from 9-15- 19 23 to 9-21 19 23.

that I last saw him alive on 9-20 19 23,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTOR (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Fred Rehmke M. D.

9-25 19 23 (Address) 1000 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 9/24 1923

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D79360

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1717 ½ Oliver ST., 8 WARD)

2-FULL NAME Infant Katkovsky

(a) RESIDENCE NO. 1717 ½ Olive ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3 hours	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Harry Katkovsky

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Tompikow

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Henry Katkovsky
(Address) 1717 E Oliver St

15 Filed SEP 24 1923 ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24. 1923

17 I HEREBY CERTIFY, That I attended deceased from ..... , 19 ..... , to ..... , 19 ..... ,

that I last saw her alive on Sept. 24 , 19 23,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) No definate Cause Known

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. W. Collenberg , M. D.

9/24, 1923 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rem

DATE OF BURIAL 9/24 1923

20 UNDERTAKER A. Plinsow & Bro

ADDRESS 1127 E Balto St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79361 ✓ 185 D79361

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 South Baltimore General Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Green. (C)

(a) RESIDENCE NO 3rd Ave & 6 th. St Fairfield. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February, 22, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER William Green. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Marshall. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Joseph Green. (C) brother. (Address) 3rd. Ave. & 6 th. St. Fairfield.

15 Filed Sep 24 1923 192 ROBERT A. KRAUTH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall down stairs from 2nd. floor.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Rembach M. D. (Coroner.)

Sept, 22. 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Accident, #1102 Olive St. Feb. 16, 1923

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Sept 24

20 UNDERTAKER C B Brook ADDRESS 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79362

CERTIFICATE OF DEATH.

31 D79362

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 Getting ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary In Higgins

(a) RESIDENCE. No. 113 Getting ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Higgins

6 DATE OF BIRTH (month, day, and year): Aug 20 1869

7 AGE: Years 54 ~~57~~ Months 1 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Geo Beilmare

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Midland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary Higgins 113 E Getting

15 Filed SEP 24 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 80 1923, to Sept 21, 1923, that I last saw her alive on Sept 21, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Chronic Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W Hammerbacher, M. D.

9-22, 1923 (Address) Right Rev. Warren Con

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 24 1923
20 UNDERTAKER	ADDRESS
Josiah Dyer	1600 N North Ave

REG. No. 2833

DR. G. HERMAN HAMMERBACHER

PHONE.

LIGHT STREET. COR. WARREN AVENUE

SOUTH 0633

HOURS 8 TO 9 30 A. M. AND 6 TO 8 P. M.

DATE

PATIENT'S NAME

ADDRESS

R

Mr Saunders
Please change the
certificate for me
Mrs Mary Higgins
Born Aug 20th 1869
I made the mistake in
her age

M. D.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79363 160 ✓ D79363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1704 Ashland Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Shearer.

(Residence in Baltimore: No. 1704 Ashland Ave. St.; 1 yrs., 1 mos. 9 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, col.

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, August 14, 1913 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Inf
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George Hodges

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Daisy Shearer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thelma Langley

(Address) 1704 Ashland Ave

15- SEP 24 1923 ROBERT E. KRAUTER, Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 22/9/1923 to ...../...../191..., that I saw h[illegible] alive on 22/9/1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH was as follows: Wasting Disease as I could determine

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration)....yrs....mos....ds.

(Signed) Murray Field Boyd M. D.

23/9/, 1923 (Address) 1041 Carlton

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Sept. 24, 1923

20-UNDERTAKER, Wm Robert A Elliott — ADDRESS 1725 Ashland Ave

Spec.--8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79364

CERTIFICATE OF DEATH.

100-00

D79364

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S Duncan ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy Respass Robinson

(Residence in Baltimore: No. 224 S. Duncan St.; 10 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, [illegible] (Month) (Day), 1848 (Year)

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 10 yrs.

9-BIRTHPLACE, (State or Country) Boy Virginia Matthews Co

PARENTS.

10-NAME OF FATHER, Armistead Gwin

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Eliza Gwin

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Respass

(Address) Hampton Va

15-

Filed SEP 24 1923 ROBERT B. [illegible], Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23rd (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1923, to Sept 23 1923, that I saw h[illegible] alive on Sept 22 1923, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alfred A Goodrich M. D.

Sept 23, 1923 (Address) 8 E Pratt Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, Sept 25 1923

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Av

Spec.—1-10-21 M&T 1500 Bks.

D79365

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

73 D79365

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 W Preston ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E Jacobs

(a) RESIDENCE NO. 311 W Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Jacobs

6 DATE OF BIRTH (month, day, and year) about 1862

7 AGE: 61 Years | Months — | Days — | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. A. C. Md

PARENTS

10 NAME OF FATHER Edward Thurat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thomas Jacobs

(Address) 1417 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

SEP 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1923, to Sept 21st, 1923, that I last saw her alive on Sept 19th, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bulbar Paralysis (duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema Intestinal Paralysis (duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Edward Ellmackenzie, M. D.

Sept 22, 1923 (Address) 1339 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Sept 24 1923

20 UNDERTAKER: Mrs A. C. Elliott — ADDRESS: 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79366

CERTIFICATE OF DEATH.

113 D79366

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 E. Bary ST. (or) WARD) 24

2-FULL NAME Mark M. Rubian

(a) RESIDENCE NO. 118 E Bary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 27-1923

7 AGE Years Months Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Mx Rubian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Viola Crump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mx Rubian 118 E Bary St

15 Filed SEP 24 1923 HUBERT R. ROUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923 to Sept 23, 1923 that I last saw h alive on Sept 28, 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H & P L Campbell M. D.

Sept 23 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westen Cemetery — DATE OF BURIAL Sept 24 1923

20 UNDERTAKER E J Timmy — ADDRESS 1460 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dorry M Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79367

D79367

CERTIFICATE OF DEATH.

Registered No. 113

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 Parkwood av St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry M. Smith

(a) Residence No. 3 Parkwood av St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 31-23

7-AGE. yrs. mos. 23 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. —

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John M Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Mary Glanster

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) John Smith (Address) 3 Parkwood av

15- Filed SEP 24 1923 ROBERT B. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 23. 23

17- I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Sept 23, 1923, that I last saw h[illegible] alive on Sept 23, 1923, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic Trouble

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wally A Cox M. D

9-24, 1923 (Address) 54 Fulton av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. LOUDON PARK

DATE OF BURIAL. 9/24 1923

20-UNDERTAKER. ROBERT BROOKS SON

ADDRESS COR CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAMES should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79368

CERTIFICATE OF DEATH.

161-001 D79368

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Barclay ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Virginia Martin

(Residence in Baltimore: No. 2529 Barclay St.; X yrs., X mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, SEP (Month) 14 (Day), 1923 (Year)

7-AGE, X yrs. X mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Victor Martin

11-BIRTHPLACE OF FATHER (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER Florence Wells

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Hileman

(Address) 2529 Barclay st.

15-

Filed ....., 191.... Howard F. Harrison Registrar.

SEP 24 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, SEP (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from SEP 14 1923 191, to SEP 23 1923 191, that I saw h alive on SEP 23 1923 191, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Intoxication of Uterus
Neonatorum aged
2 months prematurebirth.

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Duke M. D.

SEP 24 1923, 191... (Address) 928 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery. DATE OF BURIAL, Sept 25, 1923

20-UNDERTAKER Geo. J. Rux ADDRESS 1735 Mayford av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should carefully CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D79369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79369

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mdgen Hospl. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willard F. Day

(a) RESIDENCE NO. 251 W Hoffman St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) late Lucy F Day

6 DATE OF BIRTH (month, day, and year) June 25-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	8		

8 OCCUPATION OF DECEASED Batt. American

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Demville V. Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Williamsburg

14 Informant Willard F Day

(Address) Staunton Virginia

15 Filed Sept 25, 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21. 23

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13. 23, 19 to Sept. 21. 23, 19, that I last saw him alive on Sept. 21. 23, 19, and that death occurred, on the date stated above, at 9 30 p m.

The CAUSE OF DEATH* was as follows:

Cystic Liver Abscess

Peritonitis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Nephritis, Senility

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) No Acompanied, M. D.

, 19 (Address) Mdgen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown W Va.

DATE OF BURIAL Sept 25 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North

SEP 24 1923

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. If none, state so. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79370

CERTIFICATE OF DEATH.

X 90 D79370

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apts. ST., W WARD)

2-FULL NAME Harriett Isabel Crosby

(a) RESIDENCE NO. Homewood Apts ST., W WARD Boston - Mass.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? 61 yrs. 2 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Crosby

6 DATE OF BIRTH (month, day, and year) July - 15 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Boston, Mass.

PARENTS

10 NAME OF FATHER Geo. Warren

11 BIRTHPLACE OF FATHER (city or town) Manchester (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Nellie Hatch

13 BIRTHPLACE OF MOTHER (city or town) Manchester (State or country) New Hampshire

14 Informant Mrs John C. Stall - Sister (Address) Homewood Apts

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Sept 24, 1923.

that I last saw h alive on Sept 24, 1923,

and that death occurred, on the date stated above, at 5.15 a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Valv. Endocarditis, Cardiac Asthma

(duration) [illegible] mos [illegible] ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferies Buck M. D.

9/24 1923 (Address) 2846 82 Dane 82

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester - New Hampshire

DATE OF BURIAL Sept 27 1923

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS 1019 W. NORTH AVE.

Robert F. Garrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE... should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex... TION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D79371

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D79371

REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. North Bend Lane (On City side of Limits) ST.: 28 WARD)

2-FULL NAME Mary Morris Kummer

(Residence in Baltimore: No. North Bend Lane ST.: 38 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: April 9, 1844 (Month) (Day) (Year)

7 AGE: 79 yrs. 5 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jos. Talbott Pancoast

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Ann Nibling

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederic Arnold Kummer Jun

(Address) North Bend Lane - City

15 Filed SEP 24 1923, 191 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 23, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1923, to. Sept 23 1923, that I saw h[illegible] alive on Sept 23, 1923, and that death occurred, on the date stated above, at 9 1/2 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Marshall B Hurd M. D.

Sept 23, 1923 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 25/ 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS: 106 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79372 D79372

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4212 Connecticut Ave ST.: Irvington WARD) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Gruenbein

(Residence in Baltimore: No. 4212 Connecticut Ave Irvington St.; 73 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 28, 1855
(Month) (Day) (Year)

7-AGE, 67 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Adam Gruenbein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katherine Gihart

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Gruenbein

(Address) 4212 Connecticut Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

C 24923 Asst. Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23rd, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Ne Nephritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) yrs. mos. 1 ds.

(Signed) Jno C Clautice Bladed M. D.
(Coroner)

Sept 26 1923 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Sept. 25, 1923

20-UNDERTAKER Mrs Mrs. John H. Teufel & Son ADDRESS 801 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D79373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79373

CERTIFICATE OF DEATH.

Registered No. C 15 185

1-PLACE OF DEATH
City of BALTIMORE: (No. Nursery E. Childs Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Braulio Flores.

(Residence in Baltimore: No. Nursery E Childs Hospital St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: Aug (Month) — (Day) 1919 (Year)

7-AGE: 4 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore md.

PARENTS:
10-NAME OF FATHER: Felix Flores
11-BIRTHPLACE OF FATHER, (State or Country): Spain
12-MAIDEN NAME OF MOTHER: Angela Chambert
13-BIRTHPLACE OF MOTHER, (State or Country): Spain

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Felix Flores
(Address) 1820 Clifton ave

15-
Filed ..... 192.....
Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull.
accidental Fall.
(Duration) 1 yrs. mos. 3 hrs. ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. 3 hrs. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner)
Sept 23 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn cem	9-25 1923
20-UNDERTAKER. Daniel Carter	ADDRESS 916 Penna ave

Spec.—1-10-21—M&T—1500 Bks.

D79374 D79374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 135

1663

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME William E. Miller

(a) RESIDENCE NO. Freeland, Md ST. ..... WARD Freeland Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Mar 9-1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas J.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Horsell

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Sep 27 1923, 19 ..... Robert P. Carlson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 23, to Sept 24, 19 23, that I last saw h alive on Sept 24, 19 23, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Benigno prostatic Hypertrophy

(duration) 3 yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hereford Md

DATE OF BURIAL Sept 26 1923

20 UNDERTAKER E. Roy Stiffler

ADDRESS 125 E. Mathias

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79375

155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No.) ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Schofield

(a) RESIDENCE NO. 1026 Williams ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ~~state~~ CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 17. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Fredrick Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co, Md

12 MAIDEN NAME OF MOTHER: Ida Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Mother), (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Sept 24, 1923, that I last saw ~~was~~ alive on Sept 24, 1923, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Septicemia (one)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Adenomyelitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of 9/22/23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Ernest Lowe, M. D.

9/24 1923 (Address) 1901 Eutaw Pl. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery

DATE OF BURIAL: Sept 27 1923

20 UNDERTAKER: W. H. Lyons

ADDRESS: 1511 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D79376

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-007 D79376

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 W. Barre - St. 22 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Carey

(a) RESIDENCE NO. 615 W. Barre St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 18. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Charles Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Cullaren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Margaret Carey
(Address): 615 W. Barre - St.

15 Filed Sept 24, 1923 Herbert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1923, to Sept 24, 1923, that I last saw h- alive on Sept 21-23, 1923, and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 3 yrs, mos ds.

CONTRIBUTORY (Secondary): Hypostatic Congestion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W M Deverett M. D.

Sept 24 1923 (Address) 64 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: M. J. Lyons

ADDRESS: 1711 Light

Spec.—1-10-21—M&T—1500 Bks.

D79377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79377

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S Exeter ST., 3 WARD)

2-FULL NAME Filomena Di Cristofari

(a) RESIDENCE NO. 229 S Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, ~~or Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carmine Di Cristofari

6 DATE OF BIRTH (month, day, and year): July 1857

7 AGE: Years 66 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Minotte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Maria Micelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Carmine Di Cristofari 229 S Exeter St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1923 to 9-20, 1923

that I last saw h[illegible] alive on 9-19, 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

Hypertension.

Cardiac Insufficiency

Valvular Lesion

(duration) 7 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Damiet, M. D.

, 19 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Sept 25 1923

20 UNDERTAKER: Geo. L. Rutter — ADDRESS: 1730 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS RECORDED EXACTLY as it appears. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 24 1923

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79378 90 D79378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 N. Milton Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Nugent

(a) RESIDENCE NO 1109 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER James Nugent

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Welsh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant John P. Rider
(Address) 1109 N. Milton Ave

15 Filed SEP 24 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Probably)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J S Postlethwaite, M. D.
(Coroner.)

9/24/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral Cemetery

DATE OF BURIAL Sept 25 1923

20 UNDERTAKER George F. Burton

ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79379 ✓ D79379

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH German Aged Home and Payson

CITY OF BALTIMORE: (No. Baltimore ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Lia Meta Reinberg

(a) RESIDENCE. NO. German aged Home ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 87 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Reinberg.

6 DATE OF BIRTH (month, day, and year): March 14 1841

7 AGE — Years: 87 — Months: 6 — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Gerhard Kampe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mathilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Records German Aged Home Balto and Payson Sts.

15 Filed SEP 25 1923 ROBERT A. HARANEDY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23" 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/20/23. 19 . to 9/23/23 . 19 , that I last saw h alive on 9/22/23 . 19 , and that death occurred, on the date stated above, at 17 noon. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John Howk, M. D

. 19 (Address) 1043 N. Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Sept 25 1923

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79380

CERTIFICATE OF DEATH.

71-002 D79380

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Gordon Kirkwood.

(a) RESIDENCE No. Frederick Turnpike - Mt Washington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2—27—1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
10 -	—	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mt Washington

PARENTS

10 NAME OF FATHER: William H Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md.

12 MAIDEN NAME OF MOTHER: Emma Schley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Hospital Records.

15 Filed SEP 25 1923, 19 ROBERT R. KRAUTER, Registrar. BURIAL PERMIT CLERK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to Sept 24, 1923.

that I last saw him alive on Sept 24 2:30 P.M. 1923,

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory Bronchopn

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Washington

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Sept 27 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Kind of Cause unknown

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79381

CERTIFICATE OF DEATH.

9 161-002

D79381

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 Fairdale Ave Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sarah Maria Kramer

(a) Residence No.... 608 Fairdale Ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 17 1923

7-AGE. ..... yrs. ..... mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balt (State or Country). Md

PARENTS.

10-NAME OF FATHER. Lawrence G Kramer

11-BIRTHPLACE OF FATHER (city or town). Balt (State or Country). Md

12-MAIDEN NAME OF MOTHER. Sarah M Burrier

13-BIRTHPLACE OF MOTHER (city or town). Balt (State or Country). Md

14- (Informant) Lawrence G. Kramer

(Address) 608 Fairdale Ave

15- Filed SEP 25 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24-23

17- I HEREBY CERTIFY, That I attended deceased from Sep 17 1923, to Sep 24 1923

that I last saw her alive on Sep 24 1923

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows: Hemorrhage from brain caused by tumor

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Emphysema

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Edward G Morgan, M. D.

, 19 (Address) 1322 Hendenson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hampden

DATE OF BURIAL. Sept 25 1923

20-UNDERTAKER. Wm Cook

ADDRESS 502 E North Ave

BOSLEY & KRAUTER, Burial Permit Clerks

SEP 25 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Vorel.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79382

CERTIFICATE OF DEATH.

31

D79382

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 N. Montford Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Vorel

(a) RESIDENCE NO. 841 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 2 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not Employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph Vorel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Czechoslovakia

12 MAIDEN NAME OF MOTHER: Agnes Vek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Czechoslovakia

14 Informant: Joseph Vorel

(Address): 840 N. Montford Ave

15 Filed SEP 25 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1923, to Sept. 22, 1923, that I last saw her alive on Sept. 22, 1923 and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent V. Foster, M.D.

, 19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: Frank Crockson — ADDRESS: 1906 Eastwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79383 182 D79383

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Foot of Cooksie St. ST., 24 WARD)

2-FULL NAME John Franz.

(a) RESIDENCE NO 1444 Cooksie St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 28, 1916.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Mathias Franz.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hungary.

12 MAIDEN NAME OF MOTHER Katie Freichman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mathias Franz. (father)
(Address) 1444 Cooksie St.

15 Filed SEP 25 1923 192 ROBERT E. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 22, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
While playing around the water.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Eberhardt, M. D.
(Coroner)

Feb, 24, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Sept 25 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79384 | 117 | D79384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 23 WARD)

2-FULL NAME Fannie McManus.

(a) RESIDENCE NO. 1730 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 7, 1908.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Employee in
(b) General nature of industry, business, or establishment in which employed (or employer): Seine factory.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Carolina.

PARENTS

10 NAME OF FATHER: Vanus McManus.

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina.

12 MAIDEN NAME OF MOTHER: Ella M. Potee.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brooklyn, Md.

14 Informant: Ella M. Deems. (mother.
(Address) 1730 Light St.

15 Filed SEP 25 192 MURRAY M. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 22, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry & autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute suppurative Appendicitis with perforation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Peritonitis.

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Sep, 24, 192[illegible] (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 25 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B. WRITE PLAINLY. USE UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79385 D79385

CERTIFICATE OF DEATH

31

REGISTERED NO. .....

1-PLACE OF DEATH Bay View Hospital 3

CITY OF BALTIMORE (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Miller

(a) RESIDENCE No. 333 S. Caroline ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE: Years 21. Months ..... Days ..... If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto, Md.

15 Filed SEP 23 1923, 19 ..... Registrar

PUBLIC R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923 to Sept 23, 1923 that I last saw h living alive on Sept 22 1923 and that death occurred, on the date stated above, at 1-0-9 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

CONTRIBUTORY (Secondary) ~~Tuberculosis~~ Pleurisy (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) H. C. Smith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: Jacob Piellowski

ADDRESS: 1156 S. Broad St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79386

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79386

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at ~~St. Joseph's Hosp.~~ John Hopkins Hosp. ward.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Waldman

(a) RESIDENCE NO 1915 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Waldman

6 DATE OF BIRTH (month, day, and year) June 8/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Custom-House 086
(b) General nature of industry, business, or establishment in which employed (or employer) Inspector (Shils)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jno. R. Waldman $r.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sallie Cottrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Clara Waldman
(Address) 1109 E. Preston St.

15 Filed SEP 25 1923 ROBERT M. KRAUTH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Myocarditis
or valvular Insuffiency
(Fell on street Chester & Ashland

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Fallen, M. D. (Coroner.)

9/24/23 192 (Address) 508 E. NOrth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Sept 25 1923
20 UNDERTAKER Mrs C. Fuller	ADDRESS 2334 Jeffers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state carefully and correctly supplied.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79387

CERTIFICATE OF DEATH.

159-002 D79387

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 405 N. Ellwood Ave ST., 6 WARD)

2-FULL NAME Charles George Whiteford

(a) RESIDENCE NO 405 N. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year) Aug 29/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johns Hopkins Hosp.

PARENTS

10 NAME OF FATHER Ralph Whiteford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Roberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ralph Whiteford
(Address) 405 N. Ellwood Ave

15 Filed SEP 25 1923 192 ROBERT B. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept24/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably acute cardiac dilitation
(full term baby but weak)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

9/25/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmont Cem — DATE OF BURIAL: Sept 25 1923.

20 UNDERTAKER: Martin Dippleton — ADDRESS: 37 S Amm St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Boehlein)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79388 D79388

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mo Gunston Ave. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M Boehlein

(a) RESIDENCE NO. 612 Baltimore St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Silver

(b) General nature of industry, business, or establishment in which employed (or employer): Smith

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: W. J. Eisenhardt

(Address): 612 Baltimore St

15 Rec'd ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-23 1923

17

I HEREBY CERTIFY, That I attended deceased from 9-15, 1923, to 9-23, 1923

that I last saw h in alive on 9-23, 1923,

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Cardio Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Jno A Tompkins M. D.

, 19 (Address) 1 Mo Gunston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmt Av

N. B.—WRITE PLAINLY, WITH CARBON INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79389

CERTIFICATE OF DEATH.

188-003 D79389

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Haase

(a) RESIDENCE NO 4709 Charles Ave (Lauraville WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Haase

6 DATE OF BIRTH (month, day, and year) May 13/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

031

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Haase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jane Haase
(Address) 4709 Charles Ave

15 Filed ..... 192 ROBERT N. KRAUTER, Registrar

SEP 25 1923

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto- accident- fractured Skull

(Inquest at 8.30 P.M. Sept 24/2

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paces, M. D. (Coroner.)

9/24/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL 9/25 192 3

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79390

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Armstead Hotel Holliday & Fayette Sts ST., 4 WARD)

2-FULL NAME Christian Dierksen

(a) RESIDENCE NO. Holliday & Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 60 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stevens

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor of C. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dierksen & Co. Bakers & Confectioners

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nicholas Dierksen

(Address) 1220 Bolton Street

15 Filed SEP 25 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1923, to Sept 23, 1923, that I last saw h~~im~~live on Sept 22, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

valvular heart disease

absent

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Carl Reitzel M. D.

Sept 23, 1923 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/25 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

1. WRITE PLAINLY, with unfading ink.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79391

CERTIFICATE OF DEATH.

164 D79391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N. Milton Ave ST., 7 WARD)

2-FULL NAME Laura J. Laebell

(a) RESIDENCE NO 914 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Laebell

6 DATE OF BIRTH (month, day, and year) Dec 23/1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Tony Pearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Buehlea Feeney
(Address) 914 N. Milton Ave

15 Filed SEP 25 1923 ROBERT N. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia (Senility)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

9/24/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore, Cem	9/25 192 3
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D79392

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D79392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Glenwood Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Sheader

(a) RESIDENCE NO. 629 Glenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) —

6 DATE OF BIRTH (month, day, and year) 9/1/1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipyard Worker

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER August Sheader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Coward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant R. Sheader (Address) 629 Glenwood ave

15 Filed SEP 25 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1923, to Sept 22, 1923, that I last saw h[illegible] alive on Sept 22, 1923, and that death occurred, on the date stated above, at 11.35 P m.

The CAUSE OF DEATH* was as follows:

Pleura Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 625 Glenwood

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Duncan, M. D.

Sept 23, 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem DATE OF BURIAL 9/25/23

20 UNDERTAKER Geo J. Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D79393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79393

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1008 Shields St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Maggie Simpson

(a) Residence No..... 1008 Shields St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE, 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)..... — 041

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pratt.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Daniel Easton

(Address) 916 Cc

15- Filed SEP 25 1923 ROBERT N. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 23 23

17- I HEREBY CERTIFY, That I attended deceased from May 20 1923, to Sept. 23 1923,

that I last saw h.. alive on Sept. 23, 1923,

and that death occurred, on the date stated above, at 9.20 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration)....yrs....mos....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) David A. Wagner M. D.

9/25, 1923 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 9-25- 1923

20-UNDERTAKER, Daniel Easton ADDRESS 916 Same.

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79394

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D79394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 S. Second ST., 16 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph John Kipp

(a) RESIDENCE No. 933 S. Md St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	1 yrs	6 mo	20	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER John A. Kipp

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Annie J. Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) Frederick Md (State or country)

14 Informant John A. Kipp (Address) 933 S. Second St.

15 Filed SEP 25 1923 ROBERT R. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ Aug 15, 1923, to Sept- 24, 1923, that I last saw him alive on Sept 23, 1923, and that death occurred, on the date stated above, at 4:50 m.

The CAUSE OF DEATH* was as follows:

Rickets —

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

Broncho-Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Nathan J. Leander M. D.

, 19 (Address) 3035 O'Donnell St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept 26 1923
20 UNDERTAKER Gichner & Gichner	ADDRESS 1737 E. Cam

NOTE.—Entries must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79395

CERTIFICATE OF DEATH.

129 D79395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 E Williamson ST., 24 WARD)

2-FULL NAME Annie Cunningham

(a) RESIDENCE NO. 106 E Williamson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Cunningham

6 DATE OF BIRTH (month, day, and year) Apr 4 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Toronto Can.

PARENTS

10 NAME OF FATHER — Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Thomas Cunningham

(Address) 100 E Williamson St.

15 Filed SEP 25 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 23, 1923, that I last saw her alive on Sept 22, 1923, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? no

Date of —

Was there an autopsy? no

What test confirmed diagnosis? Dr

(Signed) Wm E Stigler, M. D.

9/24, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Sept 26 1923

20 UNDERTAKER Robt L Turner

ADDRESS 1411 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79396

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-D79396

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Hanover ST. 23 WARD)

2-FULL NAME Rose M. Hartline

(a) RESIDENCE No. 1611 Hanover ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hy. Hartline

6 DATE OF BIRTH (month, day, and year): Aug 28/1858

7 AGE: Years 66 | Months | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm. Hy. Hartline (Address) 1611 Hanover St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Sept 23, 1923, that I last saw h alive on Sept 23, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

Signed: H. R. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: A. Howard Evans — ADDRESS: 1428 S. Charles

SEP 25 1923

ROBERT M. KRAUTER

Burial Permit Clerk

48

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79397

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Lamont Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna L. Jensen

(a) RESIDENCE. No. 1743 Lamont Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Jensen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John R. Buckmaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Bettes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Richard Jensen.
(Address) 1743 Lamont Ave.

15 Filed SEP 25 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 23. 1923. to Sept 24. 1923. that I last saw h alive on Sept 24. 1923. and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Independent (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Sept. 24. 1923 (Signed) R. L. Campbell, M. D. (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cem.	Sept. 26 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

Spec.—1-10-21—M&T—1500 Bks.

1665-40 D79398

HEALTH DEPARTMENT—CITY OF BALTIMORE D79398

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 3

CITY OF BALTIMORE: (No. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Blue

(a) RESIDENCE NO. 1522 E. Pratt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 1915

7 AGE: Years: 5 yrs; Months: —; Days: —; If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Meadie Blue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Stage Veney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: JOHNS HOPKINS HOSPITAL Record (Address)

15 Filed SEP 25 1923, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 1923 19 to Sept 24, 1923.

that I last saw him alive on Sept 24, 1923.

and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis acute, right tibia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary): Primary pneumonia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Sept 22nd 1923 Sept 23rd 1923

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Vincent Vermooten M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Sept 27 19 23

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1725 Eastlandau

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79399

CERTIFICATE OF DEATH.

113 ✓ D79399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 S Castel ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda . Lewandowski

(a) RESIDENCE NO. 407 S. Castel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18 1923

7 AGE — Years: — Months: 8 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frank. Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Agnes Kanieski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: MR Frank Lewandowski (Address) 407 S. Castel Street

15 Filed SEP 25 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25 19 23

17 I HEREBY CERTIFY, That I attended deceased from 9/18 . 19 23 . to 9/24 . 19 23 .

that I last saw h[illegible] alive on 9/24 . 19 23 ,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Ileo colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Heart failure & Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) [illegible] M. D.

. 19 23 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Sep. 26 19 23

20 UNDERTAKER: John A Weber ADDRESS: 1803 Bank st

D79400

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 V

CERTIFICATE OF DEATH.

D79400

REGISTERED NO. C

1-PLACE OF DEATH Cedar Ave near Md. Casualty Bldg.

CITY OF BALTIMORE (No.) 3630 Sycamore St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter E. Hilliams

(Residence in Baltimore: No. 3630 Sycamore St.; yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Jan. 18, 1889 (Month) (Day) (Year)

7-AGE, 34 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer): 025

9-BIRTHPLACE, (State or Country): Maryland.

PARENTS.

10-NAME OF FATHER, Frank E. Hilliams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Emma A. Niles

13-BIRTHPLACE OF MOTHER (State or Country) Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E. Hilliams

(Address) 3630 Sycamore St.

15- SEP 25 1923 ROBERT N. KRAUTER, Filed....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 23, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute dilation of heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Alcohol

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... (County) ..... 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, 9/26/....., 1923.

20-UNDERTAKER Walter Davis — ADDRESS 3307 Paine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79401

CERTIFICATE OF DEATH.

6 X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1729 Orleans St ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aminas. Lockley

(a) RESIDENCE NO. 1729 Orleans st ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
male	colord	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King queen co. va

PARENTS

10 NAME OF FATHER louis Lockley

11 BIRTHPLACE OF FATHER (city or town) (State or country) King. queen co. va

12 MAIDEN NAME OF MOTHER Jnie Prashon

13 BIRTHPLACE OF MOTHER (city or town) King an (State or country) queen co. va

14 Informant mary Lockley

(Address) 1729 orleans st

15 Filed ....., 19 ..... Registrar

ROGER N. KRAUTER,

SEP 25 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25- 1923

17

I HEREBY CERTIFY, That I attended deceased from 9-20- , 1923 , to 9-25- , 1923 ,

that I last saw h alive on 9-24- , 1923 ,

and that death occurred, on the date stated above, at 1,30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Hargill M. D.

9-25 1923 (Address) 611-N-Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
King Queen Co. Va	Sept 26 1923
20 UNDERTAKER	ADDRESS 631
Edward Bryan	Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79402

CERTIFICATE OF DEATH.

D79402

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Michael

(a) RESIDENCE NO. 32 N. Dallas St. ST., WARD South Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	~~Single~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~1852~~ ~~1858~~ 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~45~~ 55				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Henry Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Wilby Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Municipal Hospital Records. (Address)

15 Filed SEP 25 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Sept. 23, 1923, that I last saw h im alive on Sept. 22, 1923, and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 4 mos. (last) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Bruce, M. D.

9-24-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury cemetery

DATE OF BURIAL Sept 27 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

September 27, 1923.

Mr. Geo. H. Grese
Health Department.
Baltimore, Md.

Dear Mr. Grese:

Apparently there has been a mistake made in the age given on the death certificate of Henry Michael. On the insurance application the given age is 45 and apparent age 55. I would appreciate it if you would change the age from 61 to 55.

Thanking you very kindly, I am

Yours truly,

Claude G. Dean
Resident Physician.

CGD/MAH.

Dr Dean told me over the Phone the Insurance papers he signed the age was given as 45 yrs apparent 55 yrs

he mailed the death Certificate to correct to Geo H Grese

SEP 27 19[illegible]

Dr Grace

Told me over the Phone the Insurance

Papers he fill out the age was given as 45 yrs apparently

50 yrs old. he wanted the Death Certificate to correspond

Geo H Greer

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D79403

REGISTERED NO. D79403

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 Forrest ST., 5 WARD)

2-FULL NAME Mora Powell

(a) RESIDENCE NO 339 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan Dunn

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	40	years		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Known
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Police Dept.

14 Informant
(Address)

15 Filed SEP 25 1923, 192 ROBERT N. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dis. heart
Chr. alcoholism

(Duration) Don't Know yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)
Sept 25 1923 (Address) 1059 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

IMPORTANT. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79404 CERTIFICATE OF DEATH. 31 D79404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Burke

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 631

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Erie, Pa.

PARENTS

10 NAME OF FATHER John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Payson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Municipal Hospital Records. (Address) UNIVERSITY OF MARYLAND

15 Filed SEP 25 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 19 23

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 19 23, to Sept. 19, 19 23, that I last saw h im alive on Sept. 19, 19 23, and that death occurred, on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude J Hunt M. D.

9-20-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL SEP 25 1923 19

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY WITH INDELIBLE INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

393

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79405

CERTIFICATE OF DEATH.

74-001 D79405

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lombardy Apts

CITY OF BALTIMORE: (No. 40 E St Stuney Russ. 17 WARD)

2-FULL NAME Walden Casey Rimmo

(a) RESIDENCE NO. 40 E St Stuney Russ. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~ or divorced HUSBAND of (or) ~~WIFE~~ of: Ida Colton Rimmo

6 DATE OF BIRTH (month, day, and year): June 10th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	53	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Financier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Rush Rimmo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant: Ida Colta Rimmo

(Address) 40 E Stuney Russ

15 Filed ..... , 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18th , 1923 , to Sept 24th , 1923 ,

that I last saw him alive on Sept 23d , 1923 ,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Cerebral Hemorrhage paralizing the right side of the body

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Paralysis of right side

(Signed) John L Crampton, M. D.

, 19 (Address) 1825 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: J Henkins & Son — ADDRESS: Gilmor & Mt Holly

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79406

CERTIFICATE OF DEATH.

185 D79406

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Penn) Mt Hope Retreat ST., 28 WARD)

2-FULL NAME (Rev.) H. A. Asmuth

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Louis Mo.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mt Hope Retreat Mt Hope Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to September 27, 1923,

that I last saw him alive on September 27, 1923,

and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonal Mania.

Arterio-sclerosis and senility.

One (duration) 12 yrs. mos Two ds.

CONTRIBUTORY (Secondary) Fracture of Coxa of femur Hypostatic Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thomas P. Wall, M. D.

, 19 (Address) Wyke Av. Rodgers Fd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Sept 29 1923

20 UNDERTAKER: Martin Feeley Co — ADDRESS: 1817 N Nor...

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79407

63 D79407

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 W Lanvale ST., 19 WARD)

2-FULL NAME Minnie Gregorius

(a) RESIDENCE NO. 2812 W Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 47 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 22 1881

7 AGE: 42 Years 11 Months 3 Days. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Christian Gregorius

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Roddinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Rose Gregorius 2812 W Lanvale St

15 Filed SEP 24 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): SEP 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1923, to Sept 24th, 1923, that I last saw her alive on Sept 24, 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart with Pulmonary Congestion

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Addisons Disease

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Consultation Dr O'Hara

(Signed) C. S. Parker, M. D.

19 (Address) 3123 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: SEP 27 1923, 19

20 UNDERTAKER: Geo W Little

ADDRESS: 2700

INFORMATION, WHICH CAN ONLY BE GIVEN BY THE NEAREST RELATIVE PRESENT AT DEATH, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79408

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6310 York Rd. ST., 27 WARD)

2-FULL NAME Thomas Millard Curran Faulkner

(a) RESIDENCE NO. 6310 York Rd. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura L. Greenizen

6 DATE OF BIRTH (month, day, and year) Aug 20 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Thomas Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Annie Emmitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs Laura Faulkner (Address) 5- Millbourne Penn

15 Filed SEP 6 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from May-16, 1923, to Sept. 24, 1923, that I last saw him alive on Sept 24, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Haas, M. D.

Sept 24, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Penn Cemetery	Sept 28 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E Fayette

THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D79409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Welch

(a) RESIDENCE NO. Municipal Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records. (Address)

15 Filed SEP 25 1923 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to Sept. 22, 1923,

that I last saw him alive on September 22, 1923,

and that death occurred, on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Right Hemiplegia (Residual)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A Nance, M. D.

9-25 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Sept 26 DATE OF BURIAL 1923

20 UNDERTAKER Wm Cook Sons & Hoffman Co ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3414 Springdale Ave. 15 WARD)

2-FULL NAME Caroline Burruss Rawe.

(a) RESIDENCE. NO. 3414 Springdale Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Bosley Rawe

6 DATE OF BIRTH (month, day, and year) Mar. 7 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Little York, Pa.

PARENTS

10 NAME OF FATHER ? Burruss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Julia Murray.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Known.

14 Informant Mrs. Lois Neff
(Address) 3414 Springdale Ave.

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1922, to Sept. 25, 1923.

that I last saw her alive on Sept. 24th, 1923,

and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of July 27th 1923

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) Fred H. Clark, M. D.

19 (Address) 332 Forest Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept 26 1923
UNDERTAKER	ADDRESS
Harry H. Wirtz & Co	1531 Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D79411

CERTIFICATE OF DEATH

129 V D79411

Registered No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 727 E 20th St. Ward 9)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G Pavers

(Residence in Baltimore: No. 727 E 20th St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ WIDOWED OR DIVORCED (If so write the word): Single

6-DATE OF BIRTH: March 15 (Month), 1900 (Day, Year)

7-AGE: 23 yrs. mos. ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: John Pavers

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Margaret Dunn

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Pavers

(Address) 727 E. 20th St.

15

Filed SEP 25 1923 . 191 .....

Registrar

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September (Month) 23 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15th, 1923, to September 23rd 1923.

that I saw h m alive on September 22nd 1923.

and that death occurred, on the date stated above, at 2.00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. 7 d

Contributory (SECONDARY) Epilepsy

(Duration) yrs. 7 mos. 7

(Signed) F E Kelly M.

Sept 25th 1923 (Address) 700 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAU state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSI or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Sept 26, 192

20-UNDERTAKER: Geo. J. Ruth

ADDRESS: 1335 Harford

Spec.—1-10-21—M&T—1500 Bks.

D79412

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓ D79412

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 E. Hamilton Ave. ST., 27 WARD)

2-FULL NAME John George Ezell.

(a) RESIDENCE NO. 111 E. Hamilton Ave. ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ella E. Ezell

6 DATE OF BIRTH (month, day, and year): Apr. 9. 1856

7 AGE — Years: 67 Months: 5 Days: 13 If LESS than 1 day, ~~hrs. or min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman Retired 8 years

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Andrew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John F. Ezell

(Address) 111 E. Hamilton Ave.

15 Filed SEP 25 1923, 19 .....

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 19 23

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 19 23, to Sept 23, 19 23,

that I last saw him alive on Sept 22, 19 23,

and that death occurred, on the date stated above, at 4 46 A m.

The CAUSE OF DEATH* was as follows:

Hypertension Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chas F. Lehman M. D.

9/24 1923 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 25 1923

20 UNDERTAKER: Geo. F. Rutt

ADDRESS: 1735 Harford Ave.

D79413

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D79413

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1437 Homestead ST: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ruth Hoover

(Residence in Baltimore: No. 1437 Homestead ~~Color~~ yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH ~~Oct~~ June, 1 (Month) (Day) (Year)

7 AGE 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Ness

11 BIRTHPLACE OF FATHER (State or country) Balto

12 MAIDEN NAME OF MOTHER A. N. Constantine

13 BIRTHPLACE OF MOTHER (State or country) Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Hoover

(Address) 1437 Homestead

15 Sep 25 1923, 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 24 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 1923 to Sept 24 1923 that I saw h[illegible] alive on Sept 24 1923 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Fri days (Duration) yrs. mos. ds

Contributory (SECONDARY) Pulmon Edema (Duration) yrs. mos. ds

(Signed) [illegible] M. D.

Sept 24 1923 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lakewood Cemetery DATE OF BURIAL Sept 27 1923

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79414 D79414

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1509 Covington ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hpeitag

(a) RESIDENCE NO. 1509 Covington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jos. H Hpeitag

6 DATE OF BIRTH (month, day, and year): June 5 187 2

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Martin Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Not Kendon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Jos. H Hpeitag 1509 Covington St

15 Filed SEP 26 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Sept 25, 1923, that I last saw h alive on Sept 23, 1923, and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 hrs

CONTRIBUTORY - (Secondary) Acute Nephritis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Mitchell, M. D.

(Address) 1-14 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross aaC.

DATE OF BURIAL: 9-28 1923

20 UNDERTAKER: Ed B Harle

ADDRESS: 115 E Hunt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79415

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 E Fort Ave ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Lowman

(a) RESIDENCE NO. 729 E Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William M Lowman

6 DATE OF BIRTH (month, day, and year): Aug 2 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas. Reeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz. Horsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William M. Lowman

(Address) 729 E Fort Ave

15 Filed SEP 26 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Sept 24, 1923,

that I last saw her alive on Sept 24, 1923,

and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Bright disease

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Hemoplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. E. Smith, M. D.

, 19 (Address) 910 Leight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: 9-26 1923

20 UNDERTAKER: E H Harle

ADDRESS: 1536 W Fort St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79416 90 D79416

CERTIFICATE OF DEATH.

D79416

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Dover St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Warner

(Residence in Baltimore: No. 636 Dover St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Mar 7, 1863
(Month) (Day) (Year)

7-AGE, 60 yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Samuel Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER an Known

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Warner Wife

(Address) 636 Dover St

15- SEP 26 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics

Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1923, to Sept 23 1923, that I saw h Ex alive on Sept 22 1923, and that death occurred, on the date stated above, at 2 1/4 m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)..... (Duration) yrs. mos. ds.

(Signed) H. S. McCarty M. D.

9/24, 1923 (Address) 2005 Hull Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, 9/25, 1923

20-UNDERTAKER Samuel Hawley Maddox ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1929 D79417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N Poppleton ST., 18 WARD)

2-FULL NAME Robert F. Winn

(a) RESIDENCE NO. 407 N Poppleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of ~~or WIFE of~~: Mary F. Winn

6 DATE OF BIRTH (month, day, and year): ? ? 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Wms Burg Va

PARENTS

10 NAME OF FATHER: Robert Winn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mary F. Winn 407 N Poppleton St

15 Filed SEP 26 1923, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/20, 1923, to 9/22, 1923, that I last saw h alive on 9/24, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Indeterminable.

CONTRIBUTORY (Secondary): Pulmonary Edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Neville, M. D.

9/24/1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: Frank D. Handley

ADDRESS: Baltimore

Spec– 12-23-21– E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79418 — 31 ✓ — D79418

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 15 Ward)

Registered No. D79418

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Brown

(a) Residence No. 1502 Laurens st. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Brown

6-DATE OF BIRTH (month, day and year) 1896

7-AGE.			If LESS than 1 day,
27 yrs.	mos.	ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS:

10-NAME OF FATHER. Andrew Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. polly simmons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). North Carolina

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 26 1923 ROBERT A. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept.22,1923

17- I HEREBY CERTIFY, That I attended deceased from April 28 1923 to Sept. 22 1923

that I last saw her alive on Sept. 22 1923

and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 5 mos ds

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos 5 ds

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D

9-22-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Wilmington N.C.	9/25 1923
20-UNDERTAKER Lundie Hawley	ADDRESS Middle

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79419

CERTIFICATE OF DEATH.

188-003

D79419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (ST.) (WARD)

2-FULL NAME Matilda Johnson

(a) RESIDENCE NO. 245 N. Montford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Cold

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Payton Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Milton Davis
(Address): 315 N. Eden St.

15 Filed SEP 26 1923 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Automobile Accident

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner.)

Sept 25 1923 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Sept 27th 1923

20 UNDERTAKER: Milton Davis — ADDRESS: 315 N Eden St

Kreymborg.

Spec.—1-10-21—M&T—1500 Bks.

D79420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

D79420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST., 16 WARD)

2-FULL NAME Susan Kreymborg

(a) RESIDENCE NO. 1022 Eppleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Anthony Kreymborg

6 DATE OF BIRTH (month, day, and year) [illegible] 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucien Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anthony B Kreymborg

(Address) 1022 Eppleton St

15 Filed SEP 26 1923 HOWARD A. KRAETER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25 - 1923 to Sept. 22 1923, that I last saw her alive on Sept. 22 1923, and that death occurred, on the date stated above, at 4-4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

duct

(duration) 1 yr. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) Chas. C. McCardell, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Sept 26

20 UNDERTAKER Joseph Straley Sons & Fayette

ADDRESS

N. B.—WHITE PAPER, WITH CARBON FOR TWO COPIES. This form to be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79421

CERTIFICATE OF DEATH.

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S Gilmor St ST., 19 WARD)

2-FULL NAME Francis X Robinson

(a) RESIDENCE NO. 126 S Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... gnl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph F Robinson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Janet McEntire

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Fr F Robinson
(Address) 126 S Gilmor St

15 FILED SEP 26 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/23

17 I HEREBY CERTIFY, That I attended deceased from 9/21/23, 19 , to 9/24/23, 19 ,

that I last saw h— alive on 9/24/23, 19

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) 1 wk 6 wks yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) Bernard Fenny, M. D.

9/26/1923 (Address) 7 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/24/23

20 UNDERTAKER George A Finlay ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE SHOULD BE FILLED OUT IN THE PRESENCE OF INFORMANT. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

D79422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79422

57

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1601 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mary Eckhardt

(a) Residence No. 1601 Hanover St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Eckhardt

6-DATE OF BIRTH (month, day and year) Sept 14 1856

7-AGE. 67 yrs. — mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home 037

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, D. Stange

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Annie Friadry

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Mrs Annie Ellermann

(Address) 1601 Hanover St

Filed SEP 26 1923 ROBERT N. ARAUTH, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 23/23

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1923 to Sept 23 1923

that I last saw h— alive on Sept 23 — 1923

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Septic Bronchitis

(Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hollyday M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Olivet	Sept 26 1923
20-UNDERTAKER. John F. Denny	ADDRESS. 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79423

X 3 1 D79423

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 607 N Calhoun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Millard F. Carr

(a) RESIDENCE. NO. 607 N. Calhoun St. WARD. W 9a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Widowed

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Ellie Purington Carr

6 DATE OF BIRTH (month, day, and year): Mar 22 58

7 AGE: Years 65 Months 6 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Master Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): Repair of R.R. Engines

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Grafton, W. Va.

PARENTS

10 NAME OF FATHER: John A. Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore, Maryland

14 Informant: D. R. B. Johnston (Address) 607 N. Calhoun St.

15 Filed SEP 26 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1923, to Sept. 24, 1923, that I last saw h[illegible] alive on Sept. 24, 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Pneumonia.

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Porterwood, W. Va.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) Thos. E. Wilson, M. D.

, 19 (Address) 03 N. Caldwell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery, DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: Liston V. Fuss ADDRESS: 1620 St Paul

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79424

X48 D79424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital ST., 4 WARD)

2-FULL NAME John Calvin Wentz

(a) RESIDENCE NO. Union Bridge, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH CARBON INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. AGE should be stated EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Wentz

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store keeper - 034

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll County Maryland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Harry T. Snyder (Address) 4608 Reisterstown Rd.

15 Filed SEP 26 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-25 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-27, 1923, to 9-25, 1923, that I last saw him alive on 9-25, 1923, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Epithelioma cont

(duration) 1 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Stone Jr. M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanbridge

DATE OF BURIAL: 9/26 1923

20 UNDERTAKER: W M Routson

ADDRESS: 2301 N Eutaw

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Scalp

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79425

CERTIFICATE OF DEATH.

90

D79425

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1702 Dittman Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tomey ~~Dittman~~ Bradford

(Residence in Baltimore: No. 1702 Dittman Av. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, about, 1901
(Month) (Day) (Year)

7-AGE. 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Tomey Bradford

11-BIRTHPLACE OF FATHER (State or Country). S. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Holmes

(Address) 1129 Booth St.

15- SEP 26 1923

Filed, 19..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 24, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary heart disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept 25, 1923 (Address) 201 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hagood. S. C.	9-26, 1923
20-UNDERTAKER Daniel Easton	ADDRESS 916 Penna ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D79426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79426

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Watson ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Baker

(a) RESIDENCE NO 1015 Watson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hezekiah Baker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: about 54 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joseph Gilmyard

(Address): 122 East Saratoga St

15 Filed SEP 26 1923 192 ..... Registrar

ROBERT C. KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq upon (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

at once

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.
(Coroner)

Sept 25 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: 9/26 1923

20 UNDERTAKER: Jas. Jr. Skinner ADDRESS: 1625 E Broad St.

Spec.—1-10-21—M&T—1500 Bks.

Warner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79427

D79427

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 McElderry ST., 5 WARD)

2-FULL NAME Louis Warren

(a) RESIDENCE NO. 1423 McElderry ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Warner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Sarah Gross
(Address) 1423 McElderry St

15 Filed SEP 26 1923 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23- 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-2- , 1923 , to 9-23- , 1923 ,

that I last saw him alive on 9-21- , 1923 ,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

(duration) Indefinite yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pleuritis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) W. H. Carzill, M. D.

9-25-1923 (Address) 611-N-Carolin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9-27-26

20 UNDERTAKER R C Good

ADDRESS 1405 McElderry

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79428

CERTIFICATE OF DEATH.

100-801 D79428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Isonback

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If noo-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or towo) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 10, 19 21, to Sept. 21, 19 23,

that I last saw her alive on Sept. 20, 19 23,

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Mace M. D.

9-22-19 23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

DATE OF BURIAL Sept 26 1923

20 UNDERTAKER

ADDRESS

AUGUST K. KRAUTER, CHESWETH & SON, 1917 CHEWENUT AVE.

SEP 26 1923

N. B.—WHITE PLAINLY, WITH INDELIBLE INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79429

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S. Durham ST., 7 WARD)

2-FULL NAME Frank Reed

(a) RESIDENCE NO. 133 S. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Reed

6 DATE OF BIRTH (month, day, and year) Sept 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) Terminal Warehouse

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ruthe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Charles Kissner 133 S Durham St

15 Filed ... 19 ... Registrar

SEP 26 1923 ROBERT R. KRAUTER, Deputy Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 . 19 23 . to Sept 23 19 23

that I last saw h~alive on Sept 23 19 23

and that death occurred, on the date stated above, at 1-a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Brown M. D.

(Address) 35 N. Poplar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 27 1923

20 UNDERTAKER Mendel Diffpel & Son — ADDRESS 37 S. Ann

N. B.—WHITE PLAINLY, WITH CORRECT SPELLING AND FULL GIVEN NAMES. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

(See note attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79430

CERTIFICATE OF DEATH.

66 D79430

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 Linden Ave St. 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius J. Hagan

(Residence in Baltimore: No. 2708 Linden Ave St. 29 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	White	Married

6-DATE OF BIRTH: Oct 26 1874 (Month) (Day) (Year)

7-AGE: 48 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 086
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Co

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: M. J. Hagan

11-BIRTHPLACE OF FATHER, (State or Country): Ireland.

12-MAIDEN NAME OF MOTHER: Mary Donovan

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Hagan

(Address) 2708 Linden Ave

15- Filed SEP 26 1923 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

9-27 1923 (Address) 502 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

New Cathedral Sept 28 1923

20-UNDERTAKER. ADDRESS

Wm Cook 502 E Fayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Office Hours: 8 to 9 A. M., 6 to 8 P. M.
and by Appointment

Phone, Homewood 1644
Reg. No. 1953

DR. J. J. MORRISSEY
3632 ROLAND AVENUE

℞ PATIENT'S NAME Geo. W. Morre ADDRESS 3632 Roland Ave

Dec 9/23

Geo W. Morre
Coronary Thrombosis
Arteriosclerosis
Myocarditis
Hypertension
Duration 2 yrs
Age 49 — B. 1874
Died Dec 9/23 48 yrs

HAMPDEN PHARMACY
36TH ST. & ELM AVENUE

M. D.

Plain

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person.

CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart* *phritis,* etc. The con- *rrent)* affection need Example: *Measles* *ds.; Bronchopneu-* Never report mere *tions,* such as "As- symptomatic), "At- "Convulsions," "De- e," etc.), "Dropsy," re," "Hemorrhage," Old Age," "Shock," when a definite dis- the cause. Always from child birth or *septicemia,*" "PUERP- cause for which sur- ken. For VIOLENT URY and qualify as IDAL, or as *probably* nine definitely. Ex- *Struck by railway* *und of head—homi-* *id—probably suicide.* racture of skull, and *anus)* may be stated ry."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

Cor.—1-12-23—M&T—100 Bks.

D79431

HEALTH DEPARTMENT—CITY OF BALTIMORE

1008 188

D79431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Pronounced dead at Johns Hopkins Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George B. Gephardt

(a) RESIDENCE NO 152 N. 8th St (Highlandtown) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Gephardt

6 DATE OF BIRTH (month, day, and year) April 16/1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Repair Work

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Gephardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. J. Gephardt (SON)

(Address) Chesco Ave. Rosedale

15 Filed SEP 26 1923 ROBERT R. [illegible] Registrar

Burial Permit Chart

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage-Accidental-Thrown from a horsedrawn Vehicle when horse "bolted" (Phila. rd & near North PT. Road.

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Patterson, M. D. (Coroner.)

9/25/23, 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn DATE OF BURIAL Sept 27 1923

20 UNDERTAKER Wm Cook & Son ADDRESS E. N. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79432 D79432

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 Kelley Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Geo A Yates Jr.

(a) RESIDENCE NO. 16 Kelley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 46. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Geo A Yates Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Grace Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Yates

(Address) 16 Kelley Ave

15 Filed SEP 26 1923, 19 ROBERT N. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to Sept 24, 1923, that I last saw h[illegible] alive on Sept 22nd 23, 19, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

Sept 24, 1923 (Address) 152 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Sept 27, 1923

20 UNDERTAKER: Dennis F. Knight & Sons — ADDRESS: Lexington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—1-10-21 M&T 1500 Bks.

Gruenhud.

D79433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D79433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 N. Milton ST., 20 WARD)

2-FULL NAME Wade H. Gruenhud

(a) RESIDENCE NO. 12 N Milton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 21 1922

7 AGE: Years — Months 3 Days 3 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto / Md

PARENTS

10 NAME OF FATHER: L H Gruenhud

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Katharine Gruenhud

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): L H Gruenhud 12 N Milton Ave

Filed SEP 26 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923, to Sept 24, 1923.

That I last saw h alive on Sept 24, 1923,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Uraemia - Colitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

Sept 26 '23 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Sept 26 1923

20 UNDERTAKER: F. B. Shippert ADDRESS: 2356 Fred'k Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79434

CERTIFICATE OF DEATH.

90 D79434

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Bank. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Maria Boone.

(a) RESIDENCE NO. 2014 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Much information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm G. Boone.

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE: Years 81; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John R. Budd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant: Fred W. Boone.

(Address) 2103 Penna ave Wash D.C.

15 Filed SEP 26 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923. to Sept 25. 1923.

that I last saw her alive on Sept 19. 1923,

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Asteno Sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Tumbleson, M. D.

1923 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: E. Balto. Cemetery.

DATE OF BURIAL: Sept. 27 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS 403 S. Wolfe St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79435

CERTIFICATE OF DEATH.

185 D79435

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Bauernfeind

(a) RESIDENCE NO 2222 Eastern Ave ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret (Rauh) Bauernfeind)

6 DATE OF BIRTH (month, day, and year) January 14/1865 inquiry

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Bargain House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Bauerfeind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Bauernfeind

(Address) 2222 Eastern Ave

15 Filed SEP 20 1923 192 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. ~~25~~/23 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture d Skull- accidentally fell in alley in rear of his home. on Sept 23/23

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patten, M. D. (Coroner)

9/26/23 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 27 1923
20 UNDERTAKER Lilly + Zeiler	ADDRESS 403 S. Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79436

CERTIFICATE OF DEATH.

H4 D79436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1808 E Madison St.; 7 WARD)

2-FULL NAME Richard Allen

(a) RESIDENCE. No. 1808 E Madison St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer $40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath Co.
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mother Dead
(Address) 1808 E Madison St

15 Filed ... 19 22 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923, to Sept 23, 1923

that I last saw h... alive on Sept 22, 1923

and that death occurred, on the date stated above, at 5.1 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dom

(Signed) H K Jungely M. D.

9 24 1923 (Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Sept 26 1923

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1726 Eastland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79437

CERTIFICATE OF DEATH.

38 D79437

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Orleans ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Schmelz

(a) RESIDENCE. NO. 1109 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roofer and Stove Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W. Schmelz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Schmelz
(Address) 928 W Lexington St

15 Filed SEP 26 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Sept 24, 1923, that I last saw him alive on Sept 24, 1923, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Uremia Paresis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

9-25, 1923 (Address) 120 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Sept 27 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Dysphtheria

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79438

CERTIFICATE OF DEATH.

100-001 ✓ D79438

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 China Street. ST., 22 WARD)

2-FULL NAME Ophelia Harrod. (C).

(a) RESIDENCE NO 806 China Street. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 20, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	--	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William Harrod. (C).

11 BIRTHPLACE OF FATHER (city or town) Paltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Coby. (C).

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co Md
(State or country)

14 Informant Wm Harrod.
(Address) 806 China St.

15 Filed SEP 28 1923, 192.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)
Sept. 26, 192 3 (Address) 104 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL 9/27/23

20 UNDERTAKER Wm H. Gotthardt ADDRESS 406 W. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D79439

CERTIFICATE OF DEATH.

19 D79439

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 7 WARD)

2-FULL NAME Albert Hicks

(a) RESIDENCE No 908 McDonough St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Md. Stel Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Charles Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rosie Wakefield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Alferd Ross (cousin)
(Address) 815 Rutland Ave

15 Filed SEP 26 1923, 192 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abcess of upper lobe right lung.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fractured jaw due to assault Aug 13/23 (duration) yrs. mos. ds.

(Signed) J S Hollan, M. D.
(Coroner)

9/26/23 192 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elmwood Lacrosse Station

DATE OF BURIAL 9/28, 1923

20 UNDERTAKER Brumbaugh Co Inc
Per Robert A Elliott

ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D79440

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

129 D79440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215 W. Montford ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Scherer

(a) RESIDENCE NO. 1215 W. Montford ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Louise Scherer

6 DATE OF BIRTH (month, day, and year) Oct 11th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louise Scherer

(Address) 1215 W. Montford ave

15 Filed , 19 Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923 to Sept. 25 1923, that I last saw living on Sept. 25 1923, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
& Aortic Regurgitation

(duration) 11 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory test

(Signed) J. Alberding Heald M. D.

9/25/1923 (Address) 1613 Fifth Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 29th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1206 Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79441

D79441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Harry Franklyn

(a) RESIDENCE NO. 2069 Cecil Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Husband of Mrs Harry Franklyn

6 DATE OF BIRTH (month, day, and year): Jan 22, 1723

7 AGE: Years: 51 yrs. Months: 8 Days: 3. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baggage Man

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: A. Kelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital. Brood

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 25, 1923, that I last saw him alive on Sept 25, 1923, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the oesophagus

Thoracic Aneurysm of Aorta

Acute Pericarditis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 18, 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Frozen section

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL: Sept 27 1923

20 UNDERTAKER: F. A. Kemp & Son ADDRESS: 7037 Hanover St

N. B.—WRITE LEGIBLY, WITH UNFADING INK. THIS CERTIFICATE, WHEN COMPLETED, BECOMES A PERMANENT RECORD, AND THE INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79442

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D79442

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Walker

(a) RESIDENCE NO. 308 W. Boston St ST., WARD Annapolis Md.

(Usual place of abode) (If non-resident give city of town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: William Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margt. Crumbley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Municipal Hospital Records.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26, 1923

17

I HEREBY CERTIFY, That I attended deceased from August 23, 1923, to Sept. 26, 1923, that I last saw her alive on Sept 25, 1923, and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Harry E. Handley M. D.

7-26, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md. Brewer's

DATE OF BURIAL: Sept. 30, 1923

20 UNDERTAKER: Louis D. Warnick

ADDRESS: Annapolis

NOTE.—WRITE CLEARLY, with ink. Fill in all items. Every question on this certificate should be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79443

D79443

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4106 Maine Ave (Howard Park) ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Marie Baumann

(a) RESIDENCE NO. 4106 Maine Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Late Louis L. Baumann

6 DATE OF BIRTH (month, day, and year) March 22 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Conrad Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Shellhorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louis R. Corbett

(Address) 4106 Maine Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Sept 25 1923,

that I last saw h alive on Sept 25, 1923,

and that death occurred, on the date stated above, at 7 56 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Symmers, M. D.

Sept 25 1923 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 28 1923

20 UNDERTAKER Jos Joerdens & Son

ADDRESS 217 S. Paca

Robert P. Garrison, Registrar

NOTE.—WRITE LEGIBLY WITH INDELIBLE INK. THIS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN: Show CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Stella Szelaga

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79444

CERTIFICATE OF DEATH.

71-001

D79444

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital ST., 3 WARD)

2-FULL NAME Stella Szyago.

(a) RESIDENCE NO. 726 S. Dallas St. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20 1916

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
6	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles Szelaga

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Anastazia Jaskolski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs. Anastazia Szelaga
(Address) 726 S. Dallas Street

15 Filed SEP 28 1923, 19 ..... Registrar

Robert F. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Sept 26, 1923, that I last saw deceased alive on Sept 26, 1923, and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia 2
(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Cause undetermined

Did an operation precede death? No Date of .....

Was there an autopsy? None allowed.

What test confirmed diagnosis? .....

(Signed) Jos Schumacher, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sep. 28 1923

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

X. B. [illegible] WRITE CAREFULLY AND USE THIS BLANK FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79445

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Cherry St. Curtis Bay ST., 25 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Francis Pazourek

(a) RESIDENCE NO. 221 Cherry ST., ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ...

(b) General nature of industry, business, or establishment in which employed (or employer): Infant.

(c) Name of employer: ...

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Charles Pazourek

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Geman

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Annie Pazourek
(Address) 221 Cherry St.

15 Filed SEP 28 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1923, to Sept. 26, 1923, that I last saw him alive on Sept. 25, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Immediate Inanition ... (duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Premature birth ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Evans, M. D.

9/26, 1923 (Address) 211 Church St, Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Sept 27 19 23

20 UNDERTAKER M. D. Fynn

ADDRESS 14 Light St

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79446

CERTIFICATE OF DEATH.

129 D79446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Boyd St., 16 WARD)

2-FULL NAME Mary J. Butler

(a) RESIDENCE NO. 867 Boyd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elijah Butler

6 DATE OF BIRTH (month, day, and year): May 4th 1856

7 AGE — Years: 67 Months: 6 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework (Home)

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md.

PARENTS

10 NAME OF FATHER: Benj Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Montgomery Co Md

12 MAIDEN NAME OF MOTHER: Mitchum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co Md

14 Informant (Address): Susie R Fogue 867 Boyd St

15 Filed SEP 27 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923 to Sept 26, 1923

that I last saw be alive on Sept 25, 1923

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Senile Nephritis

(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F C Funk, M. D.

Sept 26, 1923 (Address) North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: 9-29 1923

20 UNDERTAKER: Dumb Fogue

ADDRESS 916 Fa ave

N. B.—WRITE PLAINLY, WITH PEN AND INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79447 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79447

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. ..... St. Municipal Tuberculosis Hospital Ward 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Woodberry

(a) Residence No. 527 N. Paca st. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1890

7-AGE: ....33.... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): South Carolina

PARENTS.

10-NAME OF FATHER: Jack Woodberry

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Annie Gaskay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

11- (Informant): Hospital Records

(Address): M. T. H.

13- Filed ..... 192 ..... BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15 1923 to Sept. 24 1923

that I last saw him alive on Sept. 24 1923

and that death occurred, on the date stated above, at 9.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. C. Lally M. D

9-25-23 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 9-27- 1923

20-UNDERTAKER: Daniel Easton

ADDRESS: Pa ve

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128

D79448

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 410 Orange Court ST., 18 WARD)

2-FULL NAME Ollie Johnson

(a) RESIDENCE NO. 410 Orange Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 10 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Bowyer

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ollie Johnson
(Address) 410 Orange Court

15 Filed SEP 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ... yrs. Don't Know mos ... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ... yrs. ... mos. ... ds.

(Signed) W R Gonnell, M. D.
(Coroner)

Sept 26, 1923 (Address) 113 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Md.	9-27 1923
20 UNDERTAKER Daniel Easter	ADDRESS 516 E Pratt

TION is very important See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Jammi

HEALTH DEPARTMENT—CITY OF BALTIMORE

302 D79449

D79449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Miriam Jammi

(a) Residence No. 2504 E. Balto St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1921

7-AGE. .....yrs. 17 mos. .....ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Jammi

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ida Lahti

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Finland

14- (Informant) Hospital Records

(Address).....

15- Filed ..... 192.. ROBERT B. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9/26/23

17- I HEREBY CERTIFY, That I attended deceased from 9/15/23, 19.. to 9/26/23 19.., that I last saw h alive on 9/26/23, 19.., and that death occurred, on the date stated above, at 4.25a m.

The CAUSE OF DEATH* was as follows:

Swallowing peanut which lodged in bronchus.

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) .....yrs. .....mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8/10/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. W. Kalb, M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Finley Cem. DATE OF BURIAL 7/27/23, 19....

20-UNDERTAKER George A. Finley ADDRESS Fulton & Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Bernard Webster Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79450

CERTIFICATE OF DEATH.

159-001

D79450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 796 South Ann ST. 4 WARD)

2-FULL NAME Bernard Webster Johnson

(a) RESIDENCE NO. 796 South Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs 2 mos 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oliver J Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Maggie Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Oliver J Johnson (Address) 796 S Ann

15 Filed SEP 27 1923 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 25, 1923, that I last saw him alive on Sept 24, 1923, and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Abscess Encephalitis

Abscess 9 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) Walter J Dorsey, M. D.

9-26, 1923 (Address) 16 Law Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 29 1923

20 UNDERTAKER Sam W Chase Son — ADDRESS 1400 Mosher

(1) IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79451

111-001

CERTIFICATE OF DEATH.

D79451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital WARD)

2-FULL NAME Mrs Octavia Sorell

(a) RESIDENCE NO. 1217 Upton St, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — 1865

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer): Brickyard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): no

14 Informant: Emma C Lee

(Address): 1217 Upton St

15 Filed 9-27-1923, 19 ROBERT B. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-1923

17

I HEREBY CERTIFY, That I attended deceased from 9-21, 1923, to 9-25, 1923,

that I last saw him alive on 9-25, 1925,

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Local peritonis

(duration) — yrs. 7 mos 10 ds.

CONTRIBUTORY (Secondary) Ruptured gastric ulcer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-24-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Monninger M. D.

9-25, 1923 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn — DATE OF BURIAL: Sept 28, 23

20 UNDERTAKER: Sam W. Gaethon — ADDRESS: 1400 Mosher

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79452

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 Ward St St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Susie Turner

(Residence in Baltimore: No. 1222 Wood St. St. 4/ yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

6-DATE OF BIRTH. 1870
(Month) (Day) (Year)

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 0?0

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Wm Tone

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Butler

13-BIRTHPLACE OF MOTHER, (State or Country). Md Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E Tone

(Address) 1422 Maud St

15-

FILED SEP 27 1923 ROBERT B. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 26 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ill. 2 Yrs.

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. C. Bond M. D.
(Coroner.)

Sept 27 23 (Address) 1432 E Biddle

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. 9-27 1923

20-UNDERTAKER. Dud Easton

ADDRESS 816 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Vern P Northrup

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79453 X 129 D79453

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1039 N. Calvert St., (WARD) 11

2-FULL NAME V P Northrup

(a) RESIDENCE NO.... Wilmington Del St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)..... (State or country) Michigan

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) [illegible]

14 Informant J. E. Chandler

(Address) Wilmington Del.

15 Filed SEP 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept. 26, 1923, that I last saw him alive on Sept. 26, 1923, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 or 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wilmington Del.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urines other tests

(Signed) Ernest S. Crow, M. D.

, 19 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del | DATE OF BURIAL Sept 30 23

20 UNDERTAKER Wm J Pickett Sons | ADDRESS North St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D79454

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Fait Ave. St.: / WARD)

2-FULL NAME George A. Metzger

(a) RESIDENCE. No. 2727 Fait Ave. St., / WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Metzger.

6 DATE OF BIRTH (month, day, and year): July 30-1850

7 AGE — Years: 73 — Months: 1 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Sebastian Metzger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna Reinhold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mary Metzger
(Address): 2727 Fait Ave.

15 Filed . 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 25 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16th, 1923, to Sept 25th, 1923, that I last saw him alive on Sept 24th, 1923, and that death occurred, on the date stated above, at 11.57? m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

9/27/1923 (Address) 1011 N. Fallsway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stolz Redeemer Cem.

DATE OF BURIAL: Sept. 29 1923

20 UNDERTAKER: Selby & Zeile

ADDRESS: 403 S. Howard St.

INFORMATION—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79455

CERTIFICATE OF DEATH.

74-001 D79455

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 W. Belvedere Ave ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie May Shaw

(a) RESIDENCE. No. 403 W. Belvedere Ave ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank C. Shaw.

6 DATE OF BIRTH (month, day, and year) May 11 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) U. S. (State or country)

14 Informant James C. Shaw (Address) 403 Belvedere Ave

15 Filed Sep 28 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 26, 1923, that I last saw h[illegible] alive on Sept 26, 1923, and that death occurred, on the date stated above, at 9[10] A m.

The CAUSE OF DEATH* was as follows:

Paralysis,

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas J Nelle, M. D.

, 19 (Address) 7 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Sept. 28 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D79456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D79456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 E. Oliver St. ST., 8 WARD)

2-FULL NAME Henry Michel

(a) RESIDENCE NO 1510 E. Oliver St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Michel

6 DATE OF BIRTH (month, day, and year) Sept. 5/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	--	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Michel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Louise Michel (Address) 1510 E. Oliver St.

15 Filed SEP 27 1923 192 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25/1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of rectum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Culler, M. D. (Coroner.)

9/27/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept 28 192

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79457

CERTIFICATE OF DEATH.

74-001 D79457

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bertha

(a) RESIDENCE NO 1124 E. Lexington St WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... brs. or ..... min.
about 76		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Dept
(Address) Eastern Dist

15 Filed SEP 27 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Sept 27 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

THE MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... PA-
TION is very important. See instructions on back of certificate.

Robert P. Bartlett, Public Records Clerk
UNIVERSITY OF MARYLAND

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79458

161-00 D79458

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bart

(a) RESIDENCE. NO. 2331 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1923

7 AGE Years Months Days | If LESS than 1 day 21/4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hebrew Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER Harry Bart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Dora Bernstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Dora Bart
(Address) 2331 Boarbuyer

15 Filed SEP 27 1923, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1923, to Sept. 26, 1923, that I last saw h im alive on Sept 26, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature Baby-one of twins — Birth Weight 4 lbs.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor D. Fox M. D

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rizdale Cemetery | DATE OF BURIAL: Sept 27 1923

20 UNDERTAKER: Wm Levinson | ADDRESS 1127 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Loyola Southway St., (WARD)

2-FULL NAME Mary Anne McVoy.

(a) RESIDENCE NO. 2601 Loyola Southway St.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Charles A. McVoy

6 DATE OF BIRTH (month, day, and year): Dec. 8, 1855

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
67	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pennsylvania

PARENTS

10 NAME OF FATHER: James S. Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Margaret Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James Thornton McAvoy
(Address): 2601 Loyola Southway

15 Filed ..... 19 ..... Registrar

Robert P. Harrison
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/26/1923

17 I HEREBY CERTIFY, That I attended deceased from 9/17/23, 19..., to 9/26/, 19..., that I last saw h[illegible] alive on 9/26/, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. Sclerosis

(Signed) Thomas J. White M. D.

19 (Address) 401 E 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 9/28 1923

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79460

CERTIFICATE OF DEATH.

X 84

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 7

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr James Hedgley Marshall

(a) RESIDENCE NO. Leesburg, Va ST., ... WARD Leesburg Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mrs Catherine Marshall

6 DATE OF BIRTH (month, day, and year): Aug 16, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51 yrs	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): H

(c) Name of employer: H

9 BIRTHPLACE (city or town) (State or country): Wis

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): JOHNS HOPKINS HOSPITAL Record

15 Filed ..... , 19 ..... Registrar

SEP 27 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Sept 27, 1923.

that I last saw him alive on Sept 27, 1923.

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of Sept 23, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Exam.

(Signed) Warfield M. Jones, M. D.

9/27, 1923 (Address) ~~HHH~~

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LEESBURG, VA

DATE OF BURIAL: Sept 27, 1923

20 UNDERTAKER: H E Hughes

ADDRESS: Mt N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79461

CERTIFICATE OF DEATH.

113

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Spring St., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elwood C Caskey

(a) RESIDENCE NO. 1231 Spring ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Julian Caskey

11 BIRTHPLACE OF FATHER (city or town) Madeira (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Esther Schumann

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Vivian C Caskey

(Address) 1231 Spring St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923 to Sept 26, 1923

that I last saw h[illegible] alive on Sept 26, 1923

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhea

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo L McKieffer, M. D.

Sept 26, 1923 (Address) 2320 Madeira Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 29 1923
20 UNDERTAKER	ADDRESS
H. Gander & Sons	1710 Fleet St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79462

CERTIFICATE OF DEATH.

57 D79462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2912 Elliott ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Walter

(a) RESIDENCE NO. 2912 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Walter

6 DATE OF BIRTH (month, day, and year) Jan 12 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil War Pensioner

(b) General nature of industry, business, or establishment in which employed (or employer) Balto

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann M. Nicholl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Joseph L. Walter (Address) 2912 Elliott St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to Sept 25, 1923, that I last saw h[illegible] alive on Sept 24, 1923 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) m. J. McAvoy, M. D.

9/27 1923 (Address) 839 N. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept 28 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eutaw St

Robert P. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79463 ✓ X 1-002 ✓ D79463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Julia W Whaley

(a) RESIDENCE NO. 1715 W. Main St. Richmond Va. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? 51 yrs. 9 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Whaley

6 DATE OF BIRTH (month, day, and year) about Jan-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	51	9	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Patrick Button ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mt Hope Retreat

(Address) Mt Hope

Filed SEP 27 1923 . 19 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 . 1923 . to Sept 27 . 1923 .

that I last saw h[illegible] alive on Sept 26 . 1923 .

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Para-Typhoid.

(Melancholia and Exhaustion)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Toxaemia - Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic - Physical

(Signed) Dutton P. Page M. D.

. 19 (Address) Byrd St. & Ambulance Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. DATE OF BURIAL Sept 27 1923

20 UNDERTAKER STEWART & BROWN [illegible] ADDRESS [illegible] NORTH AVE.

SEP.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79464

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Laura Price

(a) RESIDENCE NO. 1900 Bolton ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? 80 yrs. 5 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 7 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80 years.	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Price

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Hynson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland.

14 Informant Mrs Howard Robinson (niece)
(Address) 1900 Bolton St.

15 Filed SEP 27 1923, 19 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Sept 27, 1923, that I last saw h alive on Sept 27, 1923, and that death occurred, on the date stated above, at 7:55 a.m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation.
Cardiac hypertrophy and dilatation (duration) yrs. mos. 17 ds.)

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No - Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) J. T. T. Hundley Jr., M. D.

9/27, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Sept 29th 1923

20 UNDERTAKER STEWART & MOWEN COMPANY — ADDRESS [redacted] NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79465

CERTIFICATE OF DEATH.

D79465

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Bastable

(Residence in Baltimore: No. 426 N Exeter St St.; 61 yrs., ... mos. ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: October (Month) 8th (Day), 1861 (Year)

7-AGE: 61 yrs. 11 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Peter McMahon

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Bridget Hanney

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward J Bastable

(Address) 426 N. Exeter St

15-

Filed ..., 191... ROBERT P. KRAUTER, Registrar.

SEP 28 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: September (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1921, to Sept 19 1923, that I saw her alive on Sept 19th 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. ... mos. ... ds.

(Signed) J. B. Saunders M. D.

Sept 26th 1923 (Address) 219 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Harford Rd.

DATE OF BURIAL: Sept 28th, 1923

20-UNDERTAKER: John E Lowry & Son

ADDRESS: 901 Gorsuch Ave

Per J J Lowry

D79466

HEALTH DEPARTMENT—CITY OF BALTIMORE

1B ✓ D79466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2109 Ashton St. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Jos. H. Fefel Jr.

(Residence in Baltimore: No. 2109 Ashton St. St.; yrs. 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. July (Month) 17 (Day) 1923 (Year)

7-AGE. ....yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS:

10-NAME OF FATHER. Joseph H. Fefel

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Helen Romm

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Fefel

(Address) 2109 Ashton St

15-

Filed ..... 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

SEP 23 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 26 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mal Records

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Geo. Lull M.D. (Coroner)

1923 (Address) 1153 N. Gay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral — DATE OF BURIAL. Sept. 28 1923

20-UNDERTAKER. George L. Schwab — ADDRESS 2101 Fred. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Daisy Weeks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79467

CERTIFICATE OF DEATH.

101-001 D79467

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 N Pine ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Weeks

(a) RESIDENCE NO. 525 N Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C[illegible]	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer Thos. Swift & Co.

9 BIRTHPLACE (city or town) (State or country) Louisa Co. Va.

PARENTS

10 NAME OF FATHER Henry Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lulia Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mildred Harris

(Address) 939 T St N.W. Wash D.C

15 Filed SEP 28 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 1923, to Sept 27 1923.

that I last saw h[illegible] alive on Sept 26 1923.

and that death occurred, on the date stated above, at 2.55 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C

DATE OF BURIAL Sept 28 1923

20 UNDERTAKER Saml B Hensley

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79468 D79468

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N. Spring ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE. No. 532 N. Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 5, 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Hensley

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mary Williams
(Address) 532 N. Spring St.

15 Filed SEP 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1923, to Sept 26, 1923, that I last saw h[illegible] alive on Sept 26, 1923, and that death occurred, on the date stated above, at 11.4, m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Probably (Measles)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

9.27.1923 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Sept 28 19

20 UNDERTAKER: R. L. Gross — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Jenny P. Levy.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79469

CERTIFICATE OF DEATH.

129 D79469

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D79469

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Lennox ST., 13 WARD)

2-FULL NAME Jenny P. Levy

(a) RESIDENCE NO. 721 Lennox ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Levy

6 DATE OF BIRTH (month, day, and year): Jany. 18, 1851

7 AGE — Years: 72 — Months: 8 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Selig G. Putzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophie Neuberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr. Ed. Levy 721 Lennox St.

15 Filed SEP 28 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/27/1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Sept 27, 1923, that I last saw her alive on Sept 27, 1923, and that death occurred, on the date stated above, at 3 58 9 m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis- chronic nephritis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopay? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Leitz M. D.

9/27, 1923 (Address) 2040 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem.

DATE OF BURIAL: 9/30/1923

20 UNDERTAKER: David Sondheim ADDRESS 1820 Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Stewart Hamilton

CERTIFICATE OF DEATH.

D79470 — REGISTERED NO. D79470

90

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 207 Aisquith ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamilton Stewart

(a) RESIDENCE. NO. 207 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natore of Industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Mary Handy
(Address) 207 Aisquith St

15 Filed SEP 26 1923 Robert F. Kraus Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to Sept 26, 1923, that I last saw h.e alive on Sept 24, 1923, and that death occurred, on the date stated above, at 10 00 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) J. Edward Finkes, M. D.

9-26, 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery.	Sept. 28 1923
20 UNDERTAKER	ADDRESS 322 N. Schroeder St.
H. H. Williams	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79471

CERTIFICATE OF DEATH.

129 D79471

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2244 Cecil Ave ST., 9 WARD)

2-FULL NAME Margaret S. Fragner

(a) RESIDENCE NO. 2244 Cecil Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alphonsus Fragner

6 DATE OF BIRTH (month, day, and year) July 5, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Kennedy

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margt.

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Alphonsus J. Fragner
(Address) 2244 Cecil Ave

15 Filed SEP 28 1923 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-25 .1923. to 9-27 .1923.
that I last saw h alive on 9-26 .1923.
and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Bernard Goss, M. D.

9/27 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	9/29 1923

20 UNDERTAKER R. C. Weidefeld. ADDRESS 904 Fremont Ave.

Spec.—1-10-21—M&T—1500 Bks.

D79472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79472

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 Harford Ave. 10 WARD)

2-FULL NAME Carrie M Kilduff

(a) RESIDENCE NO. 1237 Harford Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen J. Kilduff

6 DATE OF BIRTH (month, day, and year) July 30 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Kuehn

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Stephen J. Kilduff (Address) 1237 Harford Ave

15 Filed SEP 28 1923 ROBERT R. KNAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from October 6th 1923, to September 25 1923, that I last saw h[illegible] alive on September 25 1923 and that death occurred, on the date stated above, at 2.15 P.m.

The CAUSE OF DEATH was as follows:

Cancer Breast

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Howard Kaplan M. D.

9/26/1923 (Address) 730 E. Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL; CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 9/29 1923

20 UNDERTAKER H. C. Weisfeld ADDRESS 914 Gunmount St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79473 **CERTIFICATE OF DEATH.** 139 D79473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 W. Biddle St. ST., 11 WARD)

2-FULL NAME Isabella Law

(a) RESIDENCE NO 314 W. Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Law

6 DATE OF BIRTH (month, day, and year) about 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md. Sept. 22 1923

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Law
(Address) 314 W. Biddle St.

15 Filed SEP 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibroid Tumor of Uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. C. Hennessy, M. D. (Coroner.)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL SEP 29 1923

20 UNDERTAKER ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79474

CERTIFICATE OF DEATH.

100-001

D79474

1-PLACE OF DEATH Bay View Hospital. 5 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Brooks.

(a) RESIDENCE NO. 1119 N. Eldery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Blk.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant

(Address)

15 Date SEP 28 1923 Registrar ROBERT R. KRAUTER, Registrar of Vital Records.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1923. to Sept. 25, 1923.

that I last saw her alive on Sept. 25, 1923,

and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile dementia with Intoxication,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) H. E. Counts M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

D79475

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D79475

CERTIFICATE OF DEATH

Registered No.....

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Calvert & Saratoga St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Courlander (Courlaender)

(a) Residence No. 206 E. Eager St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4/15/1863

7-AGE. 60 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Bernard Courlander

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eluise

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Paris France

11- (Informant) Hospital Records

(Address).....

15- Filed....., 192.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/27/23

17- I HEREBY CERTIFY, That I attended deceased from June 13, 1923 to Sept. 27, 1923.

That I last saw h.. alive on Sept. 27, 1923

and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) yrs. mos. 5 Min

18-Where was disease contracted if not at place of death? In Baltimore Md.

Did an operation precede death? Yes Date of 8/4/23

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy

(Signed) K. W. Galley M. D

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. Sept. 29, 1923

20-UNDERTAKER. Henry W. Mears & Son

ADDRESS 805 N. Calvert

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79476

D79476

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francy Paul.

(a) RESIDENCE NO. 1760 Bank. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Factory

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital (Address)

15 Filed ..., 19...

ROBERT P. HARRISON, Registrar

Burial Permit Clerk.

SEP 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec 13, 1923, to Sept. 27, 1923;

that I last saw her alive on Sept. 27, 1923;

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Luetic Infection.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical + Serological findings

(Signed) H. Goldsmith, M. D.

9/27, 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Oct 1 1923

20 UNDERTAKER John A. Weber

ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79477

CERTIFICATE OF DEATH.

179 D79477

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 702 E. Biddle ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Eccleston

(a) RESIDENCE. No. 702 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10 1843

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	80	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary . Mumma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Anna L. Waters
(Address) 710 Cator Ave

15 Filed . 19 Registrar

SEP 28 19 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 19 23

17 I HEREBY CERTIFY, That I attended deceased from 8-10 . 1923 . to Sept 26 . 1923 that I last saw h[er] alive on Sept 26 . 1923 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Albuminuria

(Signed) Dr. [illegible] , M. D

. 19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	Sep. 29 1923

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

D79478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79478

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Ann ST., 2 WARD)

2-FULL NAME Tomas . Pika

(a) RESIDENCE NO. 802 S. Ann ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Maryanna . Pika (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep . 27 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	75	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank . Pika

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Maryanna . Pika (Address) 802 S Ann Street

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 , 1923 , to Sept. 27 1923.

that I last saw him alive on Sept. 27 1923

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Symps.

(Signed) Harry W. Rosenthal M. D.

, 19 (Address) 2323 Callow Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sep. 29 19 23

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79479

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D79479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Olivia ST. 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bedelia O'Donnell

(a) RESIDENCE NO. 1639 Warwick Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE — Years: 66 yrs. — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dennis McDonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) 1639 Warwick

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Sept 26, 1923, that I last saw her alive on Sept 26, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Ovarian cyst - malignant degeneration (duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1639 Warwick Ave

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Physical evidence

(Signed) Geo. B. Lytle, M. D.

..., 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Sept 26, 1923

20 UNDERTAKER: M. Hahey & Son — ADDRESS: 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79480

X160

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1720 W Franklin ST.; 4 WARD)

2-FULL NAME William Peter Simms

(a) RESIDENCE. No. 1720 W Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C of	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md.

PARENTS

10 NAME OF FATHER Wm R. Simms

11 BIRTHPLACE OF FATHER (city or town) Ellicott City (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy Johnson

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Md.

14 Informant William R. Simms
(Address) 1720 W Franklin St.

15 Filed SEP 28 1923, 19 ROBERT F. HARRISON, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28th 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 1923 to Sept 28 1923

that I last saw h... alive on Sept 28 1923.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suspected pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Lunch, M. D.

(Address) 707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Ellicott City Md

DATE OF BURIAL Sept 29 1923

20 UNDERTAKER Sch W M Starr

ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79481 CERTIFICATE OF DEATH. 91-00 D79481

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4105 Springdale Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Fannie Rector

(a) RESIDENCE NO. 4105 Springdale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Asa H. Rector

6 DATE OF BIRTH (month, day, and year): Nov 14th, 1837

7 AGE — Years: 85 — Months: 10 — Days: 14 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Farquir Co. Va.

PARENTS

10 NAME OF FATHER: Spencer Rector

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jane Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Clarence H. Rector, 4105 Springdale Ave

SEP 28 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep't 28th 19 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1923, to Sept 28th, 1923, that I last saw h[illegible] alive on Sept 27th, 1923, and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Rheumatic)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) several years Rheumatism (duration) yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. F. Hill, M. D.

, 19 (Address) 1208 Madeson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middleburg Loudon Co. Va.

DATE OF BURIAL: Sept 30th 1923

20 UNDERTAKER: Bertram Rote

ADDRESS 1723 N. Long Street

Spec.—1-10-21—M&T—1500 Bks.

D79482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D79482

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Edmondson Ave. ST. [illegible] WARD)

2-FULL NAME Charles J. Knorr

(a) RESIDENCE NO. 1017 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Westfall

6 DATE OF BIRTH (month, day, and year) Apr. 19, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) 026

(c) Name of employer

9 BIRTHPLACE (city or town) St. Louis
(State or country) Mo.

PARENTS

10 NAME OF FATHER Charles J. Knorr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara A. Stuart

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Miss Helen M. Knorr
(Address) 1017 Edmondson Avenue

15 SEP 28 1923 Robert P. Garrison, 19
Registrar
[illegible] Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25th, 1923, to Sept 26th, 1923,

that I last saw him alive on Sept 26th, 1923,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Pharynx

(duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death? New York City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Xray

(Signed) E. A. Knorr, M. D.

9-27 1923 (Address) 605 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 9/29 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79483

CERTIFICATE OF DEATH.

186-003

D79483

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 Fait ave ST., 1 WARD)

2-FULL NAME John Mika

(a) RESIDENCE NO 2629 Fait ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antoinette Mika

6 DATE OF BIRTH (month, day, and year) June 24/1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
49	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wood Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer Eastern Casket Co

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Mika

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Daniel V. Knighton
(Address) 2225 Fait Ave

15 Filed ....., 192 ..... Registrar
Robert F. Harrigan,
291923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Fell against rear fender automobile

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner)

Sept 28, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	29 1923
20 UNDERTAKER	ADDRESS
Johnson Weber	1803 Bank St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79484

CERTIFICATE OF DEATH.

145-001 D79484

1-PLACE OF DEATH (Colonial Hospital)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount ST., 4 WARD)

2-FULL NAME Mrs. Edith Linsky

(a) RESIDENCE No. 32 S. Eutaw ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f.

4 COLOR OR RACE w.

5 Single, Married, Widowed, or Divorced, (write the word) m.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) George W. Linsky

6 DATE OF BIRTH (month, day, and year) June 22, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) York, Pa.

PARENTS

10 NAME OF FATHER John Smeltzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) York, Pa.

12 MAIDEN NAME OF MOTHER Elsie Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York, Pa.

14 Informant (Address) Geo. W. Linsky 1835 Pennsylvania Ave.

15 Filed ..... 19 ..... Registrar

SEP 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/23 19

17

I HEREBY CERTIFY, That I attended deceased from July 11th, 19 23, to Sept. 28, 19 23.

that I last saw her alive on Sept 27, 19 23

and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows:

Septicemia and Endocarditis.

11 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure 2 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp - Septicemia - Developed.

Did an operation precede death? yes Date of July 11, 1923

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) U. A. Swanson, M. D.

19 (Address) Colonial Hosp - 1122 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London P.K. Cemetery

DATE OF BURIAL 9/30/23

20 UNDERTAKER Geo Leimbach & Son

ADDRESS 647 W. Fratt St

I. S. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79485

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 1 WARD)

2-FULL NAME Thadeus Borowicz

(a) RESIDENCE NO 510 S.Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year) Sept 20/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	xxxxx	7	

8 OCCUPATION OF DECEASED
(a) Trade, professlon or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Borowicz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agatha Borowicz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Andrew Borowicz
(Address) 510 S.Port St

15 Filed SEP 29 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Burned by spilling boiling milk over left neck & chest.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Collen, M. D.
(Coroner.)

9/29/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 9-29 1923

20 UNDERTAKER John [illegible]

ADDRESS 1803 Bank

Robert F. Carlton, Acting Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79486

CERTIFICATE OF DEATH.

90 D79486

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1928 Mc Henry St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Disney

(a) Residence No. 1928 Mc Henry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Caroline H. Disney

6-DATE OF BIRTH (month, day and year) Oct 23-1869

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Conductor 878

(b) General nature of industry, business, or establishment in which employed (or employer): United Electric Ry

(c) Name of employer:

9-BIRTHPLACE (city or town) Anne Arundel Co
(State or Country) Md

PARENTS.

10-NAME OF FATHER, Jno J. Disney

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country) Md

12-MAIDEN NAME OF MOTHER Anna Disney

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country) Md

14- (Informant) C. H. Disney

(Address) 1928 Mc Henry St

15- Filed....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-27-23

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1923 to Sept. 23-1923

that I last saw him alive on Sept 23 1923

and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
(Mitral Stenosis)

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) E. Hellen Hemmig M. D.

9/28, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. Sept 29, 1923

20-UNDERTAKER. F. B. Kuppert

ADDRESS 2236 Fred'k Ave

Spec.—1-10-21—M&T—1500 Bks.

D79487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79487

CERTIFICATE OF DEATH.

99-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1302 N. Washington ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion L. Hall

(a) RESIDENCE NO. 1302 N. Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): April 1923

7 AGE: Years | Months: 5 | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Edw. G. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Nellie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Edw. G. Hall

(Address) 1302 N. Washington St

EP 29 1923

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1922 to Sept 27 1923.

that I last saw her alive on Sept 26 1923.

and that death occurred, on the date stated above, at 1450 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General symptoms

(Signed) Adolph A. Eisenberg, M. D.

Sept 27 1923 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Sept 29 1923

20 UNDERTAKER: Geo M. Funk Son

ADDRESS: 811 N. Gay

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should give information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

16468 D79488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D79488

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Doris Talbert.

(a) RESIDENCE NO. 812 N. Belnard Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~Husband of~~ ~~Wife of~~ Father of Emma Talbert

6 DATE OF BIRTH (month, day, and year) Jan 27, 1921

7 AGE: Years 2 Months 8 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Vincent Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Chanlopka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address): Records

15 Filed ..... 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Sept 28, 1923, that I last saw her alive on Sept 28, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Dysentery (Ameba)

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Malnutrition (duration) Life yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Cultivation of Ameba, Casper Haiberg

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Cemetery DATE OF BURIAL Oct. 19..

20 UNDERTAKER: [illegible] ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 29 1923

Robert P. Garrison, [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Cross - 2409 Md Ave

D79489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 31

City of BALTIMORE (No. 128 West 25th St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Van Sear Chaney

(a) Residence No. 128 West 25th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14-1899

7-AGE, 24 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Operator 086

(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler Bro.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, E N. Chaney

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Washington Co Md

12-MAIDEN NAME OF MOTHER Minnie B Maddox

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) E N Chaney

(Address) 128 W 25th

15- Filed SEP 29 1923 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 28-23

17- I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1923, to Sept 28th, 1923

that I last saw h[illegible] alive on Sept 28th, 1923

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry G Cross M. D.

, 19 (Address) 2409 md. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, Oct 1-, 1923

20-UNDERTAKER, W P Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 29 1923 Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79490 D79490

CERTIFICATE OF DEATH.

X 23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S Marine Hospital ST. V WARD)

2-FULL NAME August Freeman

(a) RESIDENCE NO. U.S. Marine Hosp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. (ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) U.S. Marine Hosp. Balto

15 Filed SEP 29 1923 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from September 26 1923. to September 27 1923.

that I last saw him alive on September 27, 1923.

and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Encephalitis, acute hemorragic.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) M. S. Foster M.D. M. D.

9/28 1923 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 9/29 1923

20 UNDERTAKER S. Levinson & Bro

ADDRESS 1129 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79491

CERTIFICATE OF DEATH.

114 D79491

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Boone ST., 9th WARD)

2-FULL NAME Mary C. Valentine

(a) RESIDENCE NO. 1905 Boone ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm McGaw

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Flaharty

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant Mrs. Mary Nugent
(Address) 1905 Boone St.

15 Filed ..... 19 ..... Registrar

SEP 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27 1923

17 I HEREBY CERTIFY, That I attended deceased from January 25th 1923, to September 27th 1923, that I last saw h[illegible] alive on September 27th 1923, and that death occurred, on the date stated above, at 5.[illegible] p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Ulceration

(duration) ... yrs. 8 mos ... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis, Arteriosclerosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Howard E. Hurley, M. D.

19 (Address) 530 E. 30th ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Oct 1, 1923

20 UNDERTAKER W. C. Friedgen

ADDRESS 917 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79492

CERTIFICATE OF DEATH.

90 D79492

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Harford Ave ST., 10 WARD)

2-FULL NAME Luther Johnson

(a) RESIDENCE NO 811 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wapter Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Johnson (wife)
(Address) 811 Harford Ave.

15 Filed SEP 29 1923, 192 Robert F. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Cardiac Valvular Insuffiency

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Potter, M. D.
(Coroner.)

9/28/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Sept 29 1923

20 UNDERTAKER Wm. R. A. Ellis — ADDRESS Catonsville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79493

D79493

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Ruxton av. ST.: | 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Siegmund adler

(a) RESIDENCE. No. 1713 Ruxton av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adline Rosenthal Adler

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Restauranter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs. A. R. Adler

(Address) 1713 Ruxton Ave.

15 Filed SEP 29 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Sept 28, 1923, that I last saw him alive on Sept 28, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Sanderson, M. D.

, 19 (Address) 1714 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Heb. Cem.

DATE OF BURIAL: 9/30/ 1923

20 UNDERTAKER: David Londheim

ADDRESS: 118 W. Mt. Royal ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79494

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... St.: ? Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Oettinger

(a) RESIDENCE. No. ..... Greensboro, N.C. St. ..... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 28, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kinston, N.C.

PARENTS

10 NAME OF FATHER Abe Oettinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Bertha Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, N.C.

14 Informant (Address) Mr. Clarence Oettinger Kinston, N.C.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1923, to Sept. 25, 1923, that I last saw her alive on Sept. 25, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Isidor I. Frey, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kinston, N.C.	9/29/23

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt Royal Ave

9 29 23

Spec.—1-10-21—M&T—1500 Blks.

D79495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D79495

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST., 3 WARD)

2-FULL NAME Herman Spengler

(a) RESIDENCE NO. 1415 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Malec	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Spengler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Hillgate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records.

(Address)

15 [illegible] Registrar

SEP 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1923, to Sept. 26, 1923, that I last saw him alive on Sept. 26, 1923, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Terminal) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claude C. Lane, M. D.

9-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS

Commissioner Health.

per Wm E. Woodall

Burial Permit clerk

SEP 29 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79496

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St., 11 WARD)

2-FULL NAME Mrs. Helen E. Hooper

(a) RESIDENCE NO. 147 N. LaFayette ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence E. Hooper

6 DATE OF BIRTH (month, day, and year) Mch 31-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Charles C. Grafflin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Rose Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Kate T. Grafflin

(Address) 224 Rosedale Ave

15 SEP 29 1923 Robert P. Jackson, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25th, 1923, to Sept. 27th, 1923.

that I last saw h alive on Sept. 27th, 1923

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Had had 2 attacks about 5 yrs. ago. (duration) 1 yrs. 6 mos 12 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis. (duration) several years mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms only.

(Signed) O. F. Hoffman, M. D.

9/27, 1923 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Sept 29 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79497 — 161-001 — D79497

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maly Hospt ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Virginia Epper.

(Residence in Baltimore: No. West End Maly Hospt St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	white	

6-DATE OF BIRTH, 9 (Month) 27 (Day), 1923 (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	8 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), West End Maly Hospt.

PARENTS.

10-NAME OF FATHER, Peter Epper.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Wright Walker

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-27-23 191.... to 9-27-23 191....,
that I saw h[illegible] alive on 9-27-23 191....,
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

.....
.....
Premature
..... (Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration)....yrs. 8 mos....ds.

(Signed) J. C. Bauereis M. D.
9-28-, 1923 (Address) Baltimore Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Robert P. Harrison,
Commissioner Health.
Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79498 X 113 D79498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Haywood ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Obrdih Green,

(a) RESIDENCE NO. 105 Hayward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb. 21. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ~~Boston~~ (State or country) Newport News. Va

PARENTS

10 NAME OF FATHER Merritt Green,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trenton, N. C.

12 MAIDEN NAME OF MOTHER Willie Pugh,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newbern, N. C.

14 Informant Merritt Green, (Address) 105 Hayward St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29. 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25. 1923. to Sept. 29. 1923. that I last saw him alive on Sept. 29. 1923. and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? Physical Exam.

(Signed) J. Thos. Norton, M. D.

9/29/23 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Oct 1 1923

20 UNDERTAKER R C Groll — ADDRESS 1405 McElderry

ROBERT F. GARRISON.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79499

D79499

CERTIFICATE OF DEATH.

7H-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 18 Rosemont Ave ST., 27 WARD)

2-FULL NAME Anna Mary Trieka

(a) RESIDENCE NO. 18 Rosemont Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank Joseph Trieka

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	52	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsw. (at home)

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Harant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Trieka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant Anna Trieka (Address) 18 Rosemont Ave.

15 Filed SEP 29 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1922, to Sept. 26, 1923.

that I last saw her alive on Sept. 26, 1923,

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis + Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Wilkinson, M. D.

9/28, 1923 (Address) Rossburg, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 1 1923

ADDRESS 1906 Orleans Road

20 UNDERTAKER Funk & Erickson

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79500 D79500 188-608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hosp ST., WARD)

2-FULL NAME Henry Kramer

(a) RESIDENCE NO 811 Shuter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver, wagon
(b) General nature of industry, business, or establishment in which employed (or employer) Coal & Ice Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Kramer (Address) 811 Shuter St

15 Filed SEP 29 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebra and Abr. 1 injuries, accidentally fell from wagon while driving

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

Duration yrs. mos. ds.

(Signed) M. T. Talley, M. D.

(Coroner.)

Sept. 28, 1923 (Address) 839 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 1 1923

20 UNDERTAKER Frank E. Jackson

ADDRESS 1906 Gorsuch Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79501 D79501

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mrs. Hope Retreat ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Joseph Mallon

(a) RESIDENCE NO. 23 E 51st ST., New York WARD New York
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 57 yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb - 15 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Priest

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) unknown
(State or country) unknown

PARENTS

10 NAME OF FATHER Thomas Mallon

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER Anna Hughes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mrs. Hope Reeds.
(Address) Burlington

15 Filed SEP 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to September 29, 1923, that I last saw him alive on Sept 27, 1923, and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Sudden death

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Paranoic Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Ibell M. D.

, 19 (Address) Wyckoff - Rockaway, NJ

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City — DATE OF BURIAL 5/4/29 1923

20 UNDERTAKER [illegible] STEWART & [illegible] (WILLIAM P. [illegible]) — ADDRESS [illegible] NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79502

CERTIFICATE OF DEATH.

74-001 D79502

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 AShland Ave ST., 10 WARD)

2-FULL NAME Henry Fuchs

(a) RESIDENCE No. 1231 A,hland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Fuchs

6 DATE OF BIRTH (month, day, and year) July 7/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69	2	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Christman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Fuchs
(Address) 1231 Ashland Ave

15 Filed SEP 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Found dead in rear of residence

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

9/29/23, 192 (Address 508 E. NorthAve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL Oct 1 1923

20 UNDERTAKER Frank A. Fink — ADDRESS 916 E. Gay St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3V D79503

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) St. Joseph's Hospital (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Mathews

(a) RESIDENCE. No. 3106 Elliott St., Ward. First

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leonard Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Doettlaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Augusta Doettlaff (Address) 3106 Elliott St.

15 Filed SEP 30 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1923. to Sept 28, 1923.

that I last saw her alive on Sept 28, 1923.

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (probably Tubercular?).

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. B. Bronushas, M. D.

9-28, 1923 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
5th Reformed Cem	Oct 1st 1923

20 UNDERTAKER Peter Nicolaus ADDRESS 2060 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79504

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Linden Avenue ST., 14 WARD)

REGISTERED NO. 74 D79504

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Anne Mellier

(a) RESIDENCE NO. 1415 Linden Avenue ST., 14 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs 0 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henri Mellier

6 DATE OF BIRTH (month, day, and year) Sept. 18-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER William Henry

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) Scotland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) Scotland

14 Informant Miss. Hortense DeB. Mellier (Dau.)
(Address) 1415 Linden Avenue

15 Filed SEP 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1923, to 9/28, 1923, that I last saw h[illegible] alive on 9/28, 1923, and that death occurred, on the date stated above, at 5-50 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. mos 1/4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D.

9/30, 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Oct-1-23.

20 UNDERTAKER [illegible] MOWEN COMPANY — ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated E... should be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79505

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15 117

D79505

Registered No. C.....

City of BALTIMORE: (No. Hebrew Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Bertha Estelle Johnson

(Residence in Baltimore: No.... 2200-Elsinor-Av., ... St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. September-12-1880
(Month) (Day) (Year)

7-AGE. 43 yrs. 0 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Teacher in the
(b) General nature of industry, business, or establishment in which employed (or employer). Balto. Public Schools

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Charles H. Johnson

11-BIRTHPLACE OF FATHER. (State or Country). Buffalo, N.Y.

12-MAIDEN NAME OF MOTHER. Susie Holtz

13-BIRTHPLACE OF MOTHER. (State or Country) Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Edna Johnson, (Sister)

(Address) 2200-Elsinor-Av.

15- Filed SEP 30 1923, 192.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27/23, 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gangrenous small intestine (ileum) due to adhesions, resulting from appendicitis 3 yrs ago.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Gallen M. D.
(Coroner.)

9/28/23 192.. (Address) 508 E. orth Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 1/4 ds. In the State 43 yrs. 0 mos. 12 ds.

Where was disease contracted, if not at place of death? ? ? ? ? ? ?

Former or usual residence 2200-Elsinor-Av.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Oct-1-1923 19

20-UNDERTAKER	ADDRESS
STEWART & HOWEN COMPANY	108 W. NORTH AVE.

Cor.—1-12-23—M&T—100 Bks.

D79506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 D79506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sept 1011 Low St. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Simon

(a) RESIDENCE NO 2226 Low St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Simon

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Milk dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jack. Lewis
(Address) 1439 Eutaw St

15 Filed SEP 30 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to Illuminating Gas; not Homicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Sept 30, 1923 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 2 hours or more

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrersburg Pa

DATE OF BURIAL 9/30 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D79507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79507

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument & ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Harry Levy

(a) RESIDENCE. No. 1701 N. Smallwood St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Levy

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Michael Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Old Lem Leibsantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis (Address) 1429 E Baltimore St

15 Date Received SEP 30 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Sept 29, 1923, that I last saw him alive on Sept 29, 1923, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (Coron)

(duration) yrs. 7 weeks ds.

CONTRIBUTORY (Secondary) Impacted fracture of left femur (duration) yrs. 2 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Mikeru, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 9-30 1923

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D79508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D79508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 W. Ostend St. ST., 23 WARD)

2-FULL NAME Edwin C. Hill

(a) RESIDENCE NO. 120 W. Ostend St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia A. Hill

6 DATE OF BIRTH (month, day, and year) Dec. 25 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	82	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John T. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W. Hill

(Address) 120 W. Ostend St.

15 Filed SEP 30 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Sept 27, 1923, that I last saw him alive on Sept 27, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hallburn, M. D.

, 19 (Address) 1 E Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 10/1 1923

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fort

ROBERT R. KRAUTER
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

811 Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79509

161-001 ✓

D79509

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Bond ST., 1 WARD)

2-FULL NAME Willard Pinkney Jr

(a) RESIDENCE NO. 811 N Bond ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Colored

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1920

7 AGE — Years: 1923 — Months: Sept — Days: 28 — If LESS than 1 day, ~~2~~ hrs or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md's

PARENTS

10 NAME OF FATHER Willard Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Willard Pinkney

(Address) 811 N Bond St

15 Filed ..... 19 .....

SEP 30 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Sept 28, 1923.

that I last saw h— alive on Sept 28, 1923.

and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth 5 Months

Ab Birth

70 Minutes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alf Boggs ..... M. D.

, 19 (Address) 759 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion

DATE OF BURIAL: Sept 30 1923

20 UNDERTAKER: Daniel Hensley

ADDRESS: N Bdle

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79510

CERTIFICATE OF DEATH.

90 ✓

D79510

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 807 W Lombard ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Goetzl

(a) RESIDENCE. No 807 W Lombard ST., W WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Goetzl

6 DATE OF BIRTH (month, day, and year) Mar 18 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Boatman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bertha Goetzl (Address) 807 W Lombard

15 Filed SEP 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Sept 29, 1923, that I last saw h— alive on Sept 28, 1923, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gunther, M. D.

9/29, 1923 (Address) 517 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 10/1/23

20 UNDERTAKER Geo Lambert Son

ADDRESS 27 W Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. • Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79511

CERTIFICATE OF DEATH.

90 D79511

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. City Jail ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Mc" Phaden

(a) RESIDENCE No. 317 North Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Mc" Phaden

6 DATE OF BIRTH (month, day, and year) May 1 1873

7 AGE Years 50 Months 4 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bot Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Southern
(c) Name of employer Can Company

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER ? Mc" Phaden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Elizabeth Mc" Phaden
(Address) 317 N. Eden St

15 Filed SEP 30 1923 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or view) thereon and from the evidence obtained by said Coroner (Coroner, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

I Chronic Corn (Arteriosclerosis) Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. ds.

(Signed) M. Kelly, M. D.
(Coroner.)

Sept 29, 1923 (Address) 1629 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 1-1923

20 UNDERTAKER William Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D79512

HEALTH DEPARTMENT—CITY OF BALTIMORE

003

CERTIFICATE OF DEATH

188 D79512

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archer S Leonard

(Residence in Baltimore: No. 1406 Mosher St; yrs. 8 mos. 6 ds. 14)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. Mch 14 1915
(Month) (Day) (Year)

7-AGE. 8 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Danl Steward

11-BIRTHPLACE OF FATHER, (State or Country). md

12-MAIDEN NAME OF MOTHER Birdie Garner

13-BIRTHPLACE OF MOTHER, (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Birdie Steward

(Address) 1406 Mosher

15- Filed SEP 30 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident: Auto,

Fracture of Skull

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Shock:

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Geo Cullen Bloodee M. D.
(Coroner)

Sept 30 1923 (Address) 143 E Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet DATE OF BURIAL. Oct 2 1923

20-UNDERTAKER Wm H Chas Hon ADDRESS 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79513

CERTIFICATE OF DEATH.

86-001

D79513

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., WARD)

2-FULL NAME Henry Ritter

(a) RESIDENCE NO. 126 So Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 26 19[illegible]

7 AGE: Years 13 Months 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry E. Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Barbara Lenhr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Ritter

(Address): 126 S Regester St

15 Filed SEP 30 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-28 1923

17

I HEREBY CERTIFY, That I attended deceased from 9-15, 1923, to 9-28, 1923

that I last saw h[illegible] alive on 9-28, 1923

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-17-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Manning M. D.

9/26, 1923 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 2 1923

20 UNDERTAKER: Wendell Happersett Son — ADDRESS: 31-7 Gun St

Spec.—1-10-21—M&T—1500 Bks.

D79514 HEALTH DEPARTMENT—CITY OF BALTIMORE D79514

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 325 S Chester ST., 1 WARD)

2-FULL NAME John P. Welsh

(a) RESIDENCE No. 325 S. Chester ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 30th 1888

7 AGE — Years: 34 Months: 2 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Annie Stafleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Annie Welsh

(Address): 325 S. Chester St.

15 Filed SEP 30 1923, 19.... Registrar

ROBERT A. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep. 28, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sep 20, 1923, to Sep. 28, 1923, that I last saw him alive on Sep. 27, 1923 and that death occurred, on the date stated above, at 11.45a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) arw

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Passano M. D.

9.29.23, 19.... (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 10/1/1923

20 UNDERTAKER: J. A Moran — ADDRESS: 3000 E Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Blks.

D79515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79515
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2860 Woodbrook Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irmciana. Berryman

(a) RESIDENCE. NO. 2860 Woodbrook Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Newton Berryman

6 DATE OF BIRTH (month, day, and year) July 8 1857.

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker.

(b) General nature of industry, business, or establishment in which employed (or employer): Home.

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Cyrus Gardner.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. S. H. Roe. (Daughter)
(Address) 2860 Woodbrook Ave.

15 Filed OCT 1 1923, 19 ROBERT R. [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 30, 1923,

that I last saw h[illegible] alive on Sept 30, 1923,

and that death occurred, on the date stated above, at 1230 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Valvular Heart Lesion

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) T. R. Roe M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem.

DATE OF BURIAL: OCT 2 1923

20 UNDERTAKER: Robert S. Little

ADDRESS: 1710 Edmondson Ave.

Spec.—1-10-21—M&T—1500 Bks.

D79516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79516 / 79516

145-002

CERTIFICATE OF DEATH.

REGISTERED NO. D79516

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Hy.

CITY OF BALTIMORE: (No.) ..... ST., 1 WARD)

2-FULL NAME Julia Yanda

(a) RESIDENCE NO. 2914 Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Charles Yanda

6 DATE OF BIRTH (month, day, and year): Mar 6-1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
23	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Michael Bialek

11 BIRTHPLACE OF FATHER (city or town) (State or country)*: Poland

12 MAIDEN NAME OF MOTHER: Helen Brodrowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Chas Yanda

(Address) 2914 Hudson

15 Filed OCT 1 - 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 19 23, to Sept 27, 19 23.

that I last saw h e alive on Sept 27, 19 23,

and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows: Hemorrhage Cervical laceration due to childbirth.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 27, 23

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Operation

(Signed) Cayetano Pendleton, M. D.

, 19 (Address) Church Home and Hy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Oct 1 1923

20 UNDERTAKER: William Fiallowski — ADDRESS: 116 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Lorraine Reisner ✓ 79517

D 79517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001

D79517

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. WARD 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lorraine Reisner

(a) RESIDENCE No. #3 Helmar Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emile Reisener

6 DATE OF BIRTH (month, day, and year) Dec 2 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Springfield Mass.

PARENTS

10 NAME OF FATHER George McRocher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER May LeGare

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emile Reisener

(Address) #3 Helmar Apts

15 Filed OCT 1 - 1923 19

16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-22, 1923, to 9-27, 1923.

that I last saw her alive on 9-27-23

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Splenomyelogenous Leukemia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation; anemia

septicemia (duration) yrs. mos. 1 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical symptoms

What test confirmed diagnosis?

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Union Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery | DATE OF BURIAL Oct 1 1923

20 UNDERTAKER Harry N. Witzke | ADDRESS 1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D79518

HEALTH DEPARTMENT—CITY OF BALTIMORE

1883 003 D79518

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead by Dr. Knox Insley at 2938 E. Balto St ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret L. Ebenhouse

(a) RESIDENCE NO. 109 S. East Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct. 15/ 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	11	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John W.Ebenhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Liect

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John W. Ebenhouse
(Address) 109 S. East St.

15 Filed OCT 1 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiey (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull & internal injuries
Automobile accident. Inquest to
held Oct. 1/23

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. Scott Allen (Coroner), M. D.

9/30/23 192 (Address) 503 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Oct 1923

20 UNDERTAKER H. Sauder & Son

ADDRESS [illegible]

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D79519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79519

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Lydia Hutson

(Residence in Baltimore: No. 1915 E Lanvale St.; yrs. Life mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

6-DATE OF BIRTH. January (Month) 2 (Day) 1858 (Year)

7-AGE. 65 yrs. 8 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles Malloy

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Sarah J. Lokes

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorge W. Hutson

(Address) 1915 E. Lanvale St.

15- Filed OCT 1 1923 19.. ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 29 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, an- (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Fracture of Skull

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Shock (Duration) ....yrs. ....mos. 2 ds.

(Signed) G. E. Slade M. D.

Sept 29 23 (Coroner) (Address) 173 E Eng

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery — DATE OF BURIAL. Oct 2 1923

20-UNDERTAKER. H. Sander + Sons — ADDRESS 1710 Fleet St

Spec.—1-16-21—M&T—1500 Bks.

16633 D79520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79520

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. ST., WARD)

2-FULL NAME Jennie Bojaski

(a) RESIDENCE NO. 720 S. Regester St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frank Bojaski

6 DATE OF BIRTH (month, day, and year): Jan 4, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Martin Bojaski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Bojaski

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1923, to Sept 28, 1923,

that I last saw her alive on Sept 28, 1923,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Accidental Poisoning by Mushrooms

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. P. Hannon, M. D.

9/29, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Stanislaus Cem. DATE OF BURIAL: Oct 2nd 1923

20 UNDERTAKER: M. F. Sadowski ADDRESS: 905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.P.S.—400 Pks.

D79521 HEALTH DEPARTMENT—CITY OF BALTIMORE D79521

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Connolly

(a) Residence No. Fenwood Rd & Mt Wash'n Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 11, 1876

7-AGE. 47 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md. (State or Country),

PARENTS:

10-NAME OF FATHER, Patrick Connelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary McBoran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Frank Knell

(Address) Fenwood Rd

15- Filed OCT 1 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 30-23

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 19 23 to Sept 30 19 23

that I last saw h alive on Sept 29 19 23

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(Duration) yrs. 1 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) H. W. Bradley, M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Oct 2 1923

20-UNDERTAKER Wm. Reckner Sons — ADDRESS Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79522

CERTIFICATE OF DEATH.

74-001

D79522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (ST.) 15 (WARD)

2-FULL NAME Mrs Virginia Rupp.

(a) RESIDENCE NO. 2012 No Fulton ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Rupp

(Address) 2012 No Fulton Ave

15 Filed OCT 1 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Sept 29, 1923, that I last saw him alive on Sept 29, 1923, and that death occurred, on the date stated above, at 5.15 Am m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Trauma from Chronic
Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-Renal Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Labs + Phys. Exam

(Signed) H O Harper, M. D.

, 19 (Address) St Agnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 1 1923

20 UNDERTAKER	ADDRESS
Wm Fleckenstein Sons	Norfolk Va

Spec.—1-10-21—M&T—1500 Bks.

D79523

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

D79523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No.) 1112 N. Mount (ST.) 13 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emily Denford

(a) RESIDENCE NO. 1576 Retreat ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August T. Denford

6 DATE OF BIRTH (month, day and year) Dec 8 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Jos. A. Smith 1576 Retreat St.

15 Filed ....., 19.....

ROBERT R. KRAUSER
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1923, to Sept 28, 1923

that I last saw h[illegible] alive on Sept 26, 1923,

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia - 3 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Sept 27/23

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. A. Surgeon, M. D.

, 19 (Address) Resident - Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Oct. 1 1923
20 UNDERTAKER Wm. J. Pickler & Sons	ADDRESS North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 94-001

D79524

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3180 Pine St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Flora Speeks

(a) Residence No. 3182 Pine St., Ward. South Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6-DATE OF BIRTH (month, day and year) Sept 14 1857

7-AGE. 70 yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. house work

(b) General nature of industry, business, or establishment in which employed (or employer). O/H

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Bowie Md

PARENTS.

10-NAME OF FATHER, april gilit

11-BIRTHPLACE OF FATHER (city or town) (State or Country). S. C

12-MAIDEN NAME OF MOTHER, susa melet

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). S. C

14- (Informant) mamie grant

(Address) 1813 N. Fulton Ave

15- Filed OCT 1 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923 to Sept 28, 1923

that I last saw him alive on Sept 27, 1923

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

a Cute Bronchitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J R Lassey M. D.

19 (Address) 752 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn cemetery	Oct 1, 1923
20-UNDERTAKER. Edward Bryan	ADDRESS 1631 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Senile

Spec.—1-10-21—M&T—1500 Bks.

Edwin J Van Dawker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79525

CERTIFICATE OF DEATH.

10 D79525

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 Collins Av ST. 20 WARD)

2-FULL NAME Edwin Joseph Van Dawker

(a) RESIDENCE NO. 144 Collins Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 1, 1923

7 AGE: Years 5 | Months 7 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Reimond P Van Dawker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mari Judge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant R. P. Van Dawker
(Address) 144 Collins

15 Filed OCT 1 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Oct 1, 1923, that I last saw him alive on Sept 30, 1923, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones, M.D.

Oct 1 1923 (Address) 222 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Oct 1st 1923

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Paca St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79526

D79526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S. Hare. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob. Kruszewski

(a) RESIDENCE NO. 13 S. Hare. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of Rosalina Kruszewski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen'l Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob. Kruszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosalina Kruszewski (Address) 13 S. Hare. St.

Filed OCT 1 1923 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28- 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1923 to Sept 28 1923

that I last saw him alive on Sept 28 1923

and that death occurred, on the date stated above, at 10-30 A.m.

The CAUSE OF DEATH* was as follows:

Uremia Kidney stated

Cardiac Arterio

Emphysema

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ~~[illegible]~~

Did an operation precede death? No Date of...

Was there an autopsy? No

What test confirmed diagnosis? pending

(Signed) J. Fred Rupp M. D.

Sept 30 1923 (Address) 800 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL Oct 2 1923

20 UNDERTAKER William Fiallkowski ADDRESS 1018 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79527

CERTIFICATE OF DEATH.

X 44

D79527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. University Hospital, ST., 4 WARD)

2-FULL NAME Charles A Hands

(a) RESIDENCE NO. Harmons md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Agnes G Hands (wife)

6 DATE OF BIRTH (month, day, and year): Apr 4 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles A Hands

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Roach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hosp. Records.

(Address)

15 Filed . 19 ROBERT N. KRAUTER Registrar

OCT 1 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from 9-20, 1923, to 10-1, 1923.

that I last saw h(M)alive on 10-1, 1923

and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis (Stomach)

(duration) 3? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-24-23

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) R. Ogden, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cem aa Co

DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: Wm Fickus Hows

ADDRESS: North Pa

Spec.—1-10-21—M&T—1500 Bks.

D79528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 Etting ST., 13 WARD)

2-FULL NAME Mary Holton

(a) RESIDENCE NO. 2401 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of James Holton

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: 42 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Mary Co Md

PARENTS

10 NAME OF FATHER: Patrick Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Sallie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

14 Informant: James Holton

(Address): 2401 Etting St

15 Filed OCT 1 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20 1923 to Sept. 29 1923

that I last saw her alive on Sept 29 1923

and that death occurred, on the date stated above, at 12 Am.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis & Bright Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

10 (Signed) L H Wescott M. D.

10 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peter cemetery — DATE OF BURIAL: Oct 2nd 1923

20 UNDERTAKER: Joseph A Fare — ADDRESS: 2319 Dinlon St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D79529

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Clark Barrett

(a) RESIDENCE NO. 4 Overhill Road, ST., Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Barrett

6 DATE OF BIRTH (month, day, and year): Aug. 31, 1888

7 AGE — Years: 35 Months: 0 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Lumpkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John N. Barrett (Address): 4 Overhill Road

15 Filed OCT 1 - 1923 Registrar: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Sept 28, 1923, that I last saw her alive on Sept. 28, 1923, and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure &
acute pulmonary edema.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct. 1, 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79530

D79530

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1334 N. Calhoun St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie M. Johnson

(Residence in Baltimore: No. 1334 N. Calhoun St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, May 11, 1887
(Month) (Day) (Year)

7-AGE, 36 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. L. Passey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelyn Johnson

(Address) 246 Druid Hill Ave.

15- Filed OCT 1 - 1923 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept. 30 1923 (Address) 750 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Lukes Cemetery Ruxton — DATE OF BURIAL, 10/2 1923

20-UNDERTAKER George T. A. Gibson — ADDRESS 538 Lawrence

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D79531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D79531

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Pronounce daed at St. Joseph Hospital ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 2 114 Fair Oaks Ave. (Hamilton)

(a) RESIDENCE NO 1 Stephen N. Greig Jr. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 8/1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... school boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .. Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Stephen N. Grieg Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York City

12 MAIDEN NAME OF MOTHER Mattie A. Morse

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant Stephen N. Grieg Sr.
(Address) 114 Fair Oaks Ave

15 Filed OCT 1 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed skull- rt. side
Fractured lt. leg at knee.
Autotruck accident.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (Autopsy to held Oct 1/23
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Oden, M. D.
(Coroner.)
9/30/23, 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct. 1, 1923
UNDERTAKER Richard F. Cauley	ADDRESS 1108 Guilford

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D79532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79532

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.. 4 S. Amity St. WARD) 18

2-FULL NAME James E. Randall,

(a) RESIDENCE NO. 4 S. Amity St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 3 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ellen Randall.

6 DATE OF BIRTH (month, day, and year) June 27. 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber,

(b) General nature of industry, business, or establishment in which employed (or employer) Barber, 00X

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Sol. V. Randall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary L. Rahmann.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S. Md.

14 Informant Leo. Randall,
(Address) 2406 W. Baltimore St.

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28. 1923.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1923, to Sept. 28. 1923, that I last saw him alive on Sept. 28. 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
(Cause Antecedent)

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? In Army (U.S.)

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam.

(Signed) Chas. Norton, M. D.

10/1/23. (Address) 888 N. Pine St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL 10/3 1923

20 UNDERTAKER Samuel T. Hemsley.

ADDRESS 578 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 1-1923 Burial Permit Clerk

Cor.—1-12-23—M&T—100 Bks.

D79533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Standard Guano Co. Curtis Bay ST., 16 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Davis. (C).

(a) RESIDENCE NO 708 N. Carey ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. -- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Lillie Davis. (C).

6 DATE OF BIRTH (month, day, and year) July 4, 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	2	23.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Lillie Davis. (C). (wife).
(Address) 708 N. Carey St

15 OCT 1 - 1923 ROBERT R. KRAUTER
Registrar
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis. Fibrosis of the Coronary Arteries.
Acute dilatation of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Sept. 29, 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 10-1 192 3

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79534

CERTIFICATE OF DEATH.

113 D79534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1324 E Lexington ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia . Cymek

(a) RESIDENCE No. 1324 E. Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 27 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	1	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph. Cymek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia.Andrzejewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Joseph. Cymek

(Address) 1324 E. Lexington Street

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 , 1923 , to Sept 29 , 1923 ,

that I last saw her alive on Sept. 29 , 1923 ,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Infection

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Country

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger , M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Oct. 1 1923

20 UNDERTAKER for Wm M. Reber

ADDRESS 1823 Bank St

Spec.—1-10-21—M&T—1500 Blks.

D79535

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79535

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N. Broadway ST., 7 WARD)

2-FULL NAME Mary Agnes Glen

(a) RESIDENCE NO. 1022 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alexander Glen

6 DATE OF BIRTH (month, day, and year) Mar. 6, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William P. Pillsbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Miss Elizabeth M. Glen 1022 N. Broadway

15 Filed OCT 1 - 1923 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1923, to Sept. 28, 1923, that I last saw h 81 alive on " - , 1923, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe Bronchitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

Sept. 29 1923 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 10/1 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79536

CERTIFICATE OF DEATH.

D79536

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 E. Eager St ST.: 10 WARD)

2-FULL NAME. Mary S Runtan

(a) RESIDENCE. NO. 1431 E. Eager St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Runtan

6 DATE OF BIRTH (month, day, and year) Sept 26, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Solomon Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Sarah Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Sarah Marsh

(Address) 1431 E. Eager St

15 Filed , 19 Registrat

OCT 1 - 1923 ROBERT P. HEALTH Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Sept 30, 1923, that I last saw h[illegible] alive on Sept 29, 1923, and that death occurred, on the date stated above, at 3 PM a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial Stomach + Dysentery Ulcer (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of 2 yrs ago

Was there an autopsy? no

What test confirmed diagnosis? Expert

(Signed) Allen T Lemmon, M. D.

9/30 1923 (Address) 718 N Patterson Pk —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct 2, 1923

20 UNDERTAKER: William Cook

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Bks.

(Harry Klunk)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79537

CERTIFICATE OF DEATH.

57 D79537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Klunk

(a) RESIDENCE NO. 2445 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE~~ of Single

6 DATE OF BIRTH (month, day, and year) June 15 1870

7 AGE Years 53 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) M. Leary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Wilhelm Klunk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Louisa Haas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Mrs Hellmann 2445 Barclay

15 Date OCT 1 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30 19

17 I HEREBY CERTIFY, That I attended deceased from 9-19-23, 19, to 9-30-23, 19,

that I last saw h alive on 9-30-23, 19,

and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows: Diabetes Coma (Primary)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes + Chronic Gangrene

(duration) yrs. 1? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms + Urine

(Signed) [illegible] M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 2 1923

20 UNDERTAKER Wellman Cook

ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79538

CERTIFICATE OF DEATH.

185 D79538

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Moser

(a) RESIDENCE NO 21 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ANNA Moser

6 DATE OF BIRTH (month, day, and year) Dec 17/1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Moser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Anna Moser
(Address) 21. N. Washington St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Fractured Skull-
(Autopsy at Hospital)
(Fell in home)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) History of vertigo

(duration) yrs. mos. ds.

(Signed) J S [illegible] M. D.
(Coroner.)

10/1/23 192 (Address 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Oct 2 1923

20 UNDERTAKER John Merrick — ADDRESS Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79539

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D79539

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 928 W. Pratt St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Radcliff – Richardson

(a) RESIDENCE. No. 928 W. Pratt St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced + again married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George F. Richardson

6 DATE OF BIRTH (month, day, and year) Mch 17 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Gilland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Alice A. ~~Gilland~~ Keagney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Geo. F. Richardson
(Address) 928 W. Pratt St.

15 Filed . 19 Registrar

OCT 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1923, to Sept. 29, 1923, that I last saw h[illegible] alive on Sept. 28, 1923, and that death occurred, on the date stated above, at 5.25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gangrenous stomatitis

(Malignant lupus) (duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings.

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 2 19
20 UNDERTAKER	ADDRESS
John F. Doe	1200 N. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D79540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D79540
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 503 Mosher ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

2-FULL NAME Walton Smith

(Residence in Baltimore: No. 503 Mosher St.; 45 yrs., 1 mos. 1 dy.) abt. 1yr.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, abt. (Month) (Day), 1878 (Year)

7-AGE, 45 yrs. 1 mos. 1 dy.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) General 0/5

9-BIRTHPLACE, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Austin Smith

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Lucy Smith

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Donnelly

(Address) 503 Mosher St

15- OCT 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 26 1923, to Sept. 28 1923, that I saw him alive on Sept. 27 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pyelo - nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) yrs. mos. 2 ds.

(Signed) W. Dare X M. D.

Sept 27, 1923 (Address) 503 Mosher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Allendale, S. C. DATE OF BURIAL, Oct. 1, 1923

20-UNDERTAKER John M. Johnson ADDRESS 1309 Druid Hill

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79541

D79541

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 E Hoffman ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerard Thomas Cummings

(a) RESIDENCE NO. 1110 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 26/1923

7 AGE — Years — Months 4 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary T. Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: James Cummings (Address) 1110 E. Hoffman St.

15 OCT 1 - 1923 19 Registrar

ROBERT R. KRAUTER, REGISTRAR BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/30 1923

17

I HEREBY CERTIFY, That I attended deceased from 9/25, 1923, to 9/30, 1923, that I last saw h— alive on 9/30, 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Premature birth (6½-7 mo)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Bernard Wm, M. D.

, 19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Oct 1

DATE OF BURIAL 1923

20 UNDERTAKER: K. C. Wadefield

ADDRESS 914 Fremont Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79542

CERTIFICATE OF DEATH.

99-002

D79542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 18 WARD)

2-FULL NAME George W. Case

(a) RESIDENCE NO. 808 W. Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Case

6 DATE OF BIRTH (month, day, and year) Nov. 9, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter, Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ditch-Bowers Taylor

9 BIRTHPLACE (city or town) Trenton

(State or country) New Jersey

PARENTS

10 NAME OF FATHER Jeremiah Case

11 BIRTHPLACE OF FATHER (city or town) Trenton

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Jersey

14 Informant Municipal Hospital Records

(Address)

15 Filed OCT 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 19 23

17

I HEREBY CERTIFY, That I attended deceased from September 28 19 23, to September 29 19 23,

that I last saw him alive on September 28 19 23,

and that death occurred, on the date stated above, at 8:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) 14 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Purulent Polyarthritis, + Septicaemia (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy + blood culture

(Signed) Harry E. Handley, M. D.

9-29, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem DATE OF BURIAL Oct 1" 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery:* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer—

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79543

CERTIFICATE OF DEATH. X 131

D79543

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7 WARD) 1

2-FULL NAME Richard Jasper

(a) RESIDENCE NO. Long Acre Apts. W. 24 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced ~~HUSBAND OF~~ Father of W. M. Jasper

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Road

15 Filed OCT 1 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1923 19 , to Oct 1, 1923 19 , that I last saw h[illegible] alive on Oct 1, 1923, 19 , and that death occurred, on the date stated above, at 2 45 A. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Hotel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roncevarte Pa

DATE OF BURIAL: Oct 1 1923

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79544

CERTIFICATE OF DEATH.

X 44

D79544

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. Hebrew Hospital ST. 2 WARD)

2-FULL NAME Sarah Manstky

(a) RESIDENCE. No. 1820 Gaugh St ST., WARD. Wisconsin

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

Spirit Falls

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salomya manstky

6 DATE OF BIRTH (month, day, and year) July 13

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labar

(b) General nature of industry, business, or establishment in which employed (or employer) Warren Ehret Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Joseph manstky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant (Address) Mrs Salomya manstky 1820 Gaugh St

15 Filed . 19 Registrar

OCT 1 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 13 . 1923. to Sept. 30 . 1923

that I last saw h malive on Sept 30 . 1923

and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Partial Gastrectomy - Pastorin Gastro-enterostomy. 9/25

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) M. D.

. 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 1 1923

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank St

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79545

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-331 D79545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Dover ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Gardner,

(a) RESIDENCE NO. 727 Dover. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Bl.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug. 24, 1923.

7 AGE — Years | 1 Months | 6 Days | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Franklin Gardner,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Amherst. Va.

12 MAIDEN NAME OF MOTHER: Virginia Ruffin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster Va.

14 Informant: Mrs. Jordan, (Address) 727 Dover St.

15 Filed , 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1923 to Oct 1, 1923, that I last saw him alive on Sept. 30, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho – Pneumonia (Primary.)

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Physical Exam,

(Signed) Thos. Horton, M. D.

, 19 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER per Wm. E. WOODALL

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D79546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 16-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Rita Downey

(a) RESIDENCE NO. 100 S. 4th ST ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 20. 1923

7 AGE — Years: — Months: 8 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Emory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed OCT 1 - 1923 . 19 ..... Registrar

Robert F. Bartlett
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18 - 1923 to Sept 30. 1923.

that I last saw her alive on Sept 30 . 1923.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

States Media

(duration) yrs. 2½ mos. ..... ds.

CONTRIBUTORY (Secondary) Relapse of dysentery

(duration) yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Stool Cultures

(Signed) H. H. Mead, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Oct 2 1923. DATE OF BURIAL 19

20 UNDERTAKER Wm Cook ADDRESS 2 East North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79547

CERTIFICATE OF DEATH.

74 001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 728 N. Carrollton Ave ST., 10 WARD)

2-FULL NAME John Burke

(a) RESIDENCE NO 728 N. Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Burke.

6 DATE OF BIRTH (month, day, and year) about 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) (circus man)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Frank J. Kelly
(Address) 1106 W. Saratoga St.

15 Filed OCT 1 - 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

(Address) 210 Redwood St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park C

DATE OF BURIAL Oct 3 192 3

20 UNDERTAKER Jno. A. Mitchell

ADDRESS 1

Robert T. Harrison, Burial Permit Clerk

Burial Permit should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Size—12-23-21—E.B.R.S.—400 lbs.

D79548

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D79548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1124 W Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Nixon Jr.

(a) Residence No. 910 W Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Aug 22-1922

7-AGE: ....yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Balto, Md.

PARENTS:

10-NAME OF FATHER: Edward Nixon Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Lillian Ash.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md

14-
(Informant) Mrs Edward Nixon
(Address) 910 W Franklin St.

15-
Filed ....., 192.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 1 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 28 1923 to Oct 1, 1923 that I last saw h— alive on Oct 1, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia
(Primary)
(Duration) ....yrs. ....mos. 4 ds

CONTRIBUTORY (Secondary) —
(Duration) ....yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death? 910 N. Franklin St

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical

(Signed) Thos Jones M. D

10/1/23 (Address) 858 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Oct 2nd, 1923

20-UNDERTAKER: John J Cowan & Son — ADDRESS: 908 W Lafayette Ave
Ltd J J Cowan

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79549

100-001

D79549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 109 W. York St.: 27 WARD)

2-FULL NAME Earl Johnson

(a) RESIDENCE. No. 109 W. York St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Isaac Johnson
(Address) 109 W York St

15 Filed ..., 19 Robert L. Harrison
Registrar

OCT 1 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1923, to Sept 30, 1923, that I last saw him alive on Sept 30, 1923 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Lamar M. D.

(Address) 1400 W. [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 2 1923
20 UNDERTAKER Brown & Packard	ADDRESS 1140 W. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE ... RECORD. Every item of information should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79550

CERTIFICATE OF DEATH.

90 D79550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N. Patterson Pk. Ave WARD)

2-FULL NAME Mary Splaine

(a) RESIDENCE No. 904 N. Patterson Pk. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis Splaine

6 DATE OF BIRTH (month, day, and year): Nov. 1851

7 AGE: Years 71; Months 9; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Martin Loftus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mt Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Dennis Splaine

(Address) 904 N Patterson Pk. Ave

15 Filed OCT 1 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 23 to Sept 28, 19 23

that I last saw h-- alive on Sept 25, 19 23,

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

1 Mitral Regurgitation

2 Congestion Lungs

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cecile Edna Terry

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Reynolds, M. D.

Sept 28, 19 23 (Address) 500 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Oct 2nd 1923

20 UNDERTAKER: Geo M. Frick & Son

ADDRESS: 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79551

CERTIFICATE OF DEATH.

31 D79551

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Bremen ST.; Mt Winans WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Simpson

(Residence in Baltimore: No. 2108 Bremen St.; 71 yrs., — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Cold

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work oyster Shucker
(b) General nature of industry, business, or establishment in which employed (or employer) oyster

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown Simpson

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Hoffman

(Address) 2108 Bremen St Mt Winans

15- Filed OCT 2 - 1923, 191.. ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 30 (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1923, to Sept 28 1923, that I saw him alive on Sept 28 1923, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

One.

Consumption

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. Tolhall M. D.

....., 191... (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 3, 1923

20-UNDERTAKER John H Toadvine — ADDRESS 142 Hill St

Spec.—1-10-21—M&T—1500 Bks.

Sales

D79552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D79552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 230 Schroder ST., 18 WARD)

2-FULL NAME Rebecca Sales

(a) RESIDENCE NO. 230 Schroder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 14-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	20	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Bakery Helper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robert Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: George Sales

(Address) 6324 Lee St

15 Filed OCT 2 1923, 19.. ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Sept 29, 1923, that I last saw her alive on Sept 27, 1923, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John E Stewart M. D.

, 19 (Address) 704 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 2 1923

20 UNDERTAKER: C. W. Brown & Son

ADDRESS: 1800 Pratt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No autopsy

Spec.—1-10-21—M&T—1500 Blks.

D79553

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79553

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 419 E. 21st St., 12 Ward)

2-FULL NAME Mary V. Lacey

(a) RESIDENCE NO. 419 E. 21st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1911

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
12	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos E Lacey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Draper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Thos. E. Lacey

(Address) 419 E 21st St

15 Filed OCT 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to Sept 30, 1923

that I last saw her alive on Sept 30, 1923

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 dy.

CONTRIBUTORY (Secondary) Septic Endocarditis (Streptococcus)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) I W Kelly, M. D.

19 (Address) 100 N Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kerbathedral Cem

DATE OF BURIAL 10/2/1923

20 UNDERTAKER J. J. Moran

ADDRESS 300 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79554

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D79554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Albmarle ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dominik Koucie

(a) RESIDENCE NO. 19 Albmarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: about Years: 36 | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) Unknown (State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: John Malene (Address): 26 albemarle St

15 Filed ..., 192 ROBERT M. KRAUTER, Registrar

OCT 2 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 6 yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D. (Coroner)

Oct 1 —, 1923 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... ds.

Where did deceased live at time of last previous residence

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. STANISLOWAS — DATE OF BURIAL: OCT. 2. 1923

20 UNDERTAKER: JOHN GREBLIAUCKAS — ADDRESS: 425 S Paca St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D79555 PLACE OF DEATH — REGISTERED NO. D79555

CITY OF BALTIMORE: (No. 5713 Bellona Ave ST.) (27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice R. Mackenzie

(a) RESIDENCE. No. 5713 Bellona Ave WARD.
(Usual place of abode) all her life
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —
6 DATE OF BIRTH (month, day, and year): Sept 21-1873
7 AGE: Years 50 | Months — | Days 10 | If LESS than 1 day, ... hrs. or ... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9 BIRTHPLACE (city or town) (State or country): Balto City
PARENTS
10 NAME OF FATHER: Saml. MacKenzie
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Clara Smith
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md
14 Informant: Clara J. Wells
(Address): 5713 Bellona ave
15 Filed ... 19 ... Registrar
ROBERT R. KRAUTER, Burial Permit Clerk.
OCT 2-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1, 1923
17 I HEREBY CERTIFY, That I attended deceased from Mch. 12, 1923, to Oct. 1, 1923,
that I last saw h[illegible] alive on Oct. 1, 1923,
and that death occurred, on the date stated above, at 6 45 a. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) — yrs. 7 mos. — ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.
18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) C. D. Benjamin, M. D.
10/1/1923 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. — DATE OF BURIAL: Oct 3rd 1923
20 UNDERTAKER: Geo M Frick & Son — ADDRESS: 511 N Wolfe

Spec.—1-10-21—M&T—1500 Bks.

D79556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79556

49

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 228 Falls Road ST., 13 WARD)

2-FULL NAME Mary M Henry

(a) RESIDENCE NO. 228 Falls Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 63 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 1860

7 AGE: Years 63 Months ..... Days ..... If LESS than 1 day, ...hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md

PARENTS

10 NAME OF FATHER: Ernest Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mc Gough

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: William E. Henry

(Address) 228 Falls Road

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

OCT 2 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1923, to Sept 30, 1923, that I last saw her alive on Sept 30, 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Mediastinal Sarcoma

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. J. McRae, M. D.

10-1, 1923 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C

DATE OF BURIAL: Oct 2 1923

20 UNDERTAKER: Samuel H Greenley

ADDRESS: H Budd Co

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79557

Registered No. C.....

PLACE OF DEATH

City of BALTIMORE: (No. Camden Station St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edgar M. Payne

(Residence in Baltimore: No. None Relay Md St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. Nov (Month) 12 (Day) 1904 (Year)

7-AGE. 18 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiterman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Howard Co. Md

PARENTS.

10-NAME OF FATHER. Benjamin Payne

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Lydia Wesley

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Benjamin M Payne

(Address) Eldridge Md

15-

Filed OCT 2 - 1923 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 29 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I R Accident
Multiple Fractures
(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Shock
(Duration) ....yrs.....mos.....ds.

(Signed) J. M. Shields M. D.
(Coroner)
Oct 1 23 (Address) 1143 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

(Former) or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Eldridge Md

DATE OF BURIAL. Oct 2 1923

20-UNDERTAKER. Saml Wesley ADDRESS 1200 E St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79558

CERTIFICATE OF DEATH.

90 D79558

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 St Mary ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Powell

(Residence in Baltimore: No. 512 St Marys St., 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept X, 1880
(Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tooler
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Richard Powell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Duggold

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Powell

(Address) 512 St Marys

15-

Filed ....., 191.....

ROBERT R. KRAUTER,
Burial Permit Clerk.
Registrar.

OCT 2 - 1923

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1923, to Sept 29 1923, that I saw h in alive on Sept 29 1923, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
mitral incompetency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None known

(Duration) yrs. mos. ds.

(Signed) Chas J Keller M. D.

Oct 1, 1923 (Address) 222 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Clutworn Cem

DATE OF BURIAL, Oct 2, 1923

20-UNDERTAKER Daniel Stansbury

ADDRESS Md

Spec.—1-10-21—M&T—1500 Bks.

D79559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79559

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 N. Pratt ST., 20 WARD)

2-FULL NAME John Hartman

(a) RESIDENCE NO. 2506 N. Pratt ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Hartman

6 DATE OF BIRTH (month, day, and year) July 9. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54.	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Ofc'l

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christina Hartman
(Address) 2506 W. Pratt St.

15 Filed . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, . 1922. to date of death. that I last saw him alive on Sept, 30 . 1923. and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Asthma — Edema

Malignant (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Anthony La Costa M. D.

. 19 (Address) 927 N. Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Oct. 3 1923.

20 UNDERTAKER Mr. & Mrs. John W. Gimpel & Son — ADDRESS 801 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

Kaplan
2008 Eutaw Place

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79560

CERTIFICATE OF DEATH.

114 D79560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1191 N Fulton St. 16 (Ward)

2-FULL NAME Parker Joseph Gross

(a) RESIDENCE NO. 1191 N. Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ——

6 DATE OF BIRTH (month, day, and year): Aug 26 1906

7 AGE: Years 17; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Parker W. Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Grace C O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Parker W. Gross

(Address) 1191 N. Fulton

15 Filed OCT 2 1923, 19 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Sept 30, 1923, that I last saw h alive on Sept 30, 1923, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of the heart

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): Enteritis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Jos Kaplan M. D.

, 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: Oct 3, 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D79561

HEALTH DEPARTMENT—CITY OF BALTIMORE

141 D79561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Schmidt

(a) RESIDENCE NO. 700 Gay 4th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Charles Schmidt

(Address) 700 Gay 4th St Highland Town

15 Filed OCT 2 - 1923 ROBERT H. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to Sept 29, 1923, that I last saw h alive on Sept 29 - 1923, and that death occurred, on the date stated above, at 9 12 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Changes - Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 7-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 3 1923.
20 UNDERTAKER Lilly & Geiler	ADDRESS 603 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Retroversion of Uterus

D79562 HEALTH DEPARTMENT—CITY OF BALTIMORE. 66 D79562

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Colonial Hospital St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. Trostle

(Residence in Baltimore: No. 1847 Mc Henry St. St.: yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widower

6-DATE OF BIRTH, March 7, 1877
(Month) (Day) (Year)

7-AGE, 46 yrs. 6 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Elias Trostle

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER ? Kohr

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Trostle

(Address) 1340 Mc Henry St.

15-

Filed ..... 191.....

OCT 2 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, au- inquiry (topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Oct. 1, 1917 (Address) 2502 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Middletown Pa

DATE OF BURIAL, Oct. 3, 19..

20-UNDERTAKER W M Routzon

ADDRESS 2238 N Bond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79563

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2518 Maryland ST. 12 WARD)

2-FULL NAME Ralph Hooper Flaherty

(a) RESIDENCE No. 2518 Maryland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Flaherty

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John F Flaherty

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Emma Hurtt

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Gladys Flaherty
(Address) 1926 Maryland Ave

15 Filed OCT 2 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to September 29, 1923, that I last saw h m alive on September 29, 1923 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights - (Chr Uremia) and complications -

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Myocarditis - & Chronic Patent Coronary (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Louis F. Blumrein, M. D.

, 19 (Address) 722 North Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	Oct. 2 1923
20 UNDERTAKER	ADDRESS
Martin Fahey & Son	1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D79564 HEALTH DEPARTMENT—CITY OF BALTIMORE D79564

188-60

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Phila Road 411 ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Unknown

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dep't Eastern Dist
(Address)

15 Filed OCT 2 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.
THE NOBOUT.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Hemorrhage —

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cut in half — Pa. R.R. Train Ran over him

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton (Coroner.), M. D.

Sept 27, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Back 3rd

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL 192

20 UNDERTAKER ADDRESS

Commissioner of Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D79565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 113

D79565

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Genl Hosp. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moran

(a) RESIDENCE NO. Annapolis Junc Md. WARD Annapolis Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6th 1922

7 AGE — Years: 1 — Months: 2. — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Junction Md

PARENTS

10 NAME OF FATHER John moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) 3 acto md

12 MAIDEN NAME OF MOTHER Rose F. Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) John Moran 1511 Cliffview ave

15 Filed OCT 2 - 1923 ROBERT A. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-23 19

17

I HEREBY CERTIFY, That I attended deceased from 9-13-23. 19 to 10-1-23. 19

that I last saw him alive on 10-1-23, 19

and that death occurred, on the date stated above, at 1 45 A m.

The CAUSE OF DEATH* was as follows:

Uremia, Cirrhosis.

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobaris

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Jno A Tompkins, M. D.

19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Oct 3rd 1923

20 UNDERTAKER: H. C Brauning & Son.

ADDRESS 517 N. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

D79566 HEALTH DEPARTMENT—CITY OF BALTIMORE D79566

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 E. Biddle ST., 10 WARD)

2-FULL NAME Julia M. Finnan

(a) RESIDENCE NO. 925 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School .68

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Finnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Farrihan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Marcella Finnan (Address) 925 E Biddle St

15 Filed OCT 2 - 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 26th 1923 to Oct. 1st 1923, that I last saw h alive on Sept 30th 1923, and that death occurred, on the date stated above, at 1:25 am m.

The CAUSE OF DEATH* was as follows:

Uremia due to
Chronic Nephritis
Unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ch Valv. Endocarditis
Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Buell M. D.

1923 (Address) 2846 82 Penna 82

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edwards Cem DATE OF BURIAL Oct 3 1923

20 UNDERTAKER H. A. Strehlefert ADDRESS 718 Gilmor St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79567
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D79567
REGISTERED NO.

CITY OF BALTIMORE: (No. 314 South Eaton ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew W. Shields

(a) RESIDENCE. No. 314 S. Eaton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Married

6 DATE OF BIRTH (month, day, and year): May 11-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Machinest
(b) General nature of industry, business, or establishment in which employed (or employer): Porcelain Store
(c) Name of employer: Wiskittle

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: James Shields
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Margaret Brady
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

11 Informant (Address): Mrs Nellie Concannon 314 S. Eaton ave

15 Filed OCT 2 - 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to Sept. 29, 1923, that I last saw h im alive on 830 P.M. Sept 29 1923, and that death occurred, on the date stated above at Sept 30 330 AM m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
Illio Colitis for aortic Stenosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Auto accident
(duration) 2 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Brantley Schaub M. D.
, 19 (Address) 116 Rockwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

D79568 HEALTH DEPARTMENT—CITY OF BALTIMORE D79568

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Vincent ST. 16 WARD)

2-FULL NAME Edith Elliott

(a) RESIDENCE No. 926 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE colored | 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July - 1923

7 AGE Years — Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Fred Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Karl Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Karl Elliott (Address) 926 Vincent St.

15 Filed OCT 2 - 1923, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1923 to Oct 1, 1923

that I last saw her alive on Sept. 30, 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

1 wk

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. A. Inaman, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10. 3 1923

20 UNDERTAKER David Fenton

ADDRESS 5th ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79569

49

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Allendale Road ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Cole

(a) RESIDENCE NO. 2403 Allendale Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendant

(b) General nature of industry, business, or establishment in which employed (or employer) American Ice Co.

(c) Name of employer " " "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Cole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Vickers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Charles Collins
(Address) 2403 Allendale Road

15 Filed ..... , 19 .....
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1. 1923 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Oct 1, 1923,
that I last saw h alive on Sept 30, 1923,
and that death occurred, on the date stated above, at 12:00 P m.

The CAUSE OF DEATH* was as follows:

General Carcinosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O'Donovan, M. D.

Oct 4 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10-4.23 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

CT2 - 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Laura J. Stroat

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79570

CERTIFICATE OF DEATH.

90 D79570

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No. 1006 Kine St. ST.: 18 WARD)

2-FULL NAME Alfred Freeland

(a) RESIDENCE. No. 114-N. Selevedere ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE — Years: 66 — Months: — — Days: — — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rubstater

(b) General nature of industry, business, or establishment in which employed (or employer): Yard

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Md

PARENTS

10 NAME OF FATHER: John Freeland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co., Md

12 MAIDEN NAME OF MOTHER: Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mahoney.

14 Informant: Mrs. Freeland (Address) 114 N. Selevedere Ave.

15 Filed ....., 19 .....

CT 2-1923

Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Sept 30, 1923, that I last saw h[er] alive on Sept 30, 1923, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Vascular Heart Disease.

(duration) yrs. 23 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. A. Flinn M. D.

19 (Address) 211-E-23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 9/3 1923

20 UNDERTAKER: Bateman & Freeland

ADDRESS 114 N. Selevedere

Wilbut Brown

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2903 Walbrook St., 15 Ward) 90

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roxana Dorsey

(Residence in Baltimore: No. 2903 Walbrook Ave St.; 50 yrs., 1 mos., 0 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Aug. (Month) 31 (Day) 1873 (Year)

7-AGE: 50 yrs. 1 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Evan L. Dorsey

11-BIRTHPLACE OF FATHER, (State or Country): Del

12-MAIDEN NAME OF MOTHER: Rebecca Denby

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rebecca J Dorsey

(Address) 2903 Walbrook Ave

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held un inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct. 2, 1923. (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Havre de Grace — DATE OF BURIAL: Oct 3 1923

20-UNDERTAKER: Wm J Tucker Sons — ADDRESS: North Pa

OCT 2-1923 Robert E. Partlow, Burial Permit Clerk.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79572 57 D79572

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1149 E. Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Goldstein

(a) Residence No. 1149 E. Lombard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Abraham Goldstein

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
90 yrs. — mos. — ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore

15- Filed, 192... ROBERT R. KRAUTER, Registrar.

OCT 3 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/1/23

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 to Sep 30 19 23

that I last saw h[illegible] alive on Sep 24 1923

and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Diabetes

Hypertension

Chr. Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) M. Chulack M. D.

10/1 1923 (Address) Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Herrg Rm	10/3 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79573

CERTIFICATE OF DEATH.

9 ~ D79573

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 N. Spring St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Irvin Scott

(Residence in Baltimore: No. 1825 N Spring St.; ....yrs., 8 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	C	Single

6-DATE OF BIRTH, ...Jan.... (Month) 9 (Day) 1923 (Year)

7-AGE, ...yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Scott

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Rosetta Collins

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosetta Scott (mother)

(Address) 1825 N Spring St

15-

Filed OCT 3 - 1923 19.... ROBERT R. KRAUTER, Burial Permit Clerk. No.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1923, to Oct 1 1923, that I saw h[im] alive on Sept 30 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ....yrs. ....mos. ....ds.

(Signed) R J Young M. D.

Oct 1, 1923 (Address) 1729 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	Oct 3., 1923

20-UNDERTAKER	ADDRESS
Geo. J. Pentz	1735 Hayford ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Warden.

11670

D79574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001 D79574

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 5 WARD)

2-FULL NAME Beulah Warden

(a) RESIDENCE NO. 8 N. Caroline St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Lucy Johnson

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE: Years 15; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Mike Warden

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lucy Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed OCT 3 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923.

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1923. to Oct 2, 1923.

that I last saw her alive on Oct 2, 1923.

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

{ Typhoid fever
{ Intestinal hemorrhage

(duration) 0 yrs. 0 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient of Private, Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Pos. blood culture

(Signed) W. R. Hannon, M. D.

10/2, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Busy cemetery — DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: Edward Bryon — ADDRESS 1631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-19-25 M&T—1500 Bks.

D79575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79575

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH Howard A. Kelly Hosp. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1418 Eutaw Pl. (St.) (Ward) 14

2-FULL NAME Elizabeth Hall

(a) RESIDENCE NO. Parkersburg W. Va. (St.) WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 28 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Williams Hall

6 DATE OF BIRTH (month, day, and year) aug 26 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Lewis Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Rebecca Marcum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Richard Burdett
(Address) Parkersburg W. Va

15 Filed .....19..... Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

OCT 3 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1923, to Oct. 2, 1923, that I last saw her alive on Oct. 1, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colonum

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept 12, 1923

Was there an autopsy? No

What test confirmed diagnosis? Pathological section

(Signed) Arthur C. Simmons M. D.

10/2, 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland Kentucky — DATE OF BURIAL Oct. 3 1923

20 UNDERTAKER Chas. E. Black — ADDRESS 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79576

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-092 D79576

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 Gough St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth Jones

(Residence in Baltimore: No. 1822 Gough St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Jan. (Month) 17th (Day) 1842 (Year)

7-AGE. 81 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John F. Van Bobern

11-BIRTHPLACE OF FATHER, (State or Country). Holland.

12-MAIDEN NAME OF MOTHER. Harriett Williams

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Jenkins

(Address) 2209 Eastern ave.

15- OCT 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

Filed ..... 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G C Yates M. D.

Oct 2/23 192. (Coroner) (Address) 143 N Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Oct 3rd 1923
20-UNDERTAKER.	ADDRESS
Lilly & Zeiler	4033 Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D79577. 188-023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188. D79577.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital ST., (WARD) 21

2-FULL NAME Clement Carson.

(a) RESIDENCE NO 912 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. ACTS should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Genevieve Carson.

6 DATE OF BIRTH (month, day, and year) May 26, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Worker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER George Carson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Elizabeth Dingel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Genevieve Carson. (wife)
(Address) 912 Washington Blvd.

15 Filed OCT 3 - 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 30, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the neck. Pinned under an overturned automobile in which he was riding. Accidental death.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Oct, 2, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Accident at Curtis Bay Bridge.

Date of injury resulting in death September 30, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 3 1923
20 UNDERTAKER	**ADDRESS**
John A Inman	3000 E. Balto St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79578
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

49 D79578
REGISTERED NO.

CITY OF BALTIMORE: (No.) 1706 E Preston St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Liberty C Thies

(a) RESIDENCE NO. 1706 E Preston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Amelia Thies

6 DATE OF BIRTH (month, day, and year) Sept 19 1871

7 AGE: Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Thies

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Guth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Thies
(Address) 1706 E Preston St

15 Filed OCT 3 - 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept 30~~ Oct 1 - 8 1923 to Oct 1 1923; that I last saw him alive on Oct 1 1923 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

about 1 year

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Edema Heart Trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 1 in Home

Was there an autopsy? no

What test confirmed diagnosis? Cancer

(Signed) W J Riley M. D.

, 19 (Address) 1639 Bandley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 3 19 23

20 UNDERTAKER: Ralph Johnson

ADDRESS: 1 E Lanvale

Spec.—1-10-21—M&T—1500 Bks.

Human

D79579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D79579

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: (No. 19 ST., WARD)

2-FULL NAME Annie M. Human

(a) RESIDENCE NO. 210 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cobb Hill Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Elizabeth Human

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Boy View Hospital (Address)

15 Filed OCT 3 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 23, to Sept 30. 19 23

That I last saw h alive on Sept 30 19 23

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia, Type Enterococcus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. V. Edmunds, M. D.

19 (Address) Boy View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Oct 3 19 23

20 UNDERTAKER Kent H. Creacy — ADDRESS 1100 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79580 HEALTH DEPARTMENT—CITY OF BALTIMORE D79580

CERTIFICATE OF DEATH.

REGISTERED NO. 164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Eutaw St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Mitchell

(a) RESIDENCE. No. 1307 Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: George Mitchell

6 DATE OF BIRTH (month, day, and year): Jan. 21-1843

7 AGE: Years 80; Months 5; Days 10; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Pa.

PARENTS

10 NAME OF FATHER: John King

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Pa

12 MAIDEN NAME OF MOTHER: Mary Blatchly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

11 Informant: Edward King (Address) 1307 Eutaw St

15 Filed OCT 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Sept 30, 1923, that I last saw h[er] alive on Sept 30, 1923, and that death occurred, on the date stated above, at 12 40 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion 3 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Robinson M. D.

, 19 (Address) 727 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL Oct 4 1923

20 UNDERTAKER: George Schwaab ADDRESS: 1201 Park Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002 D79581

D79581

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327½ N Fulton ave ST., 15 WARD)

2-FULL NAME Vernon Clarke Knight

(a) RESIDENCE NO. 1327½ N Fulton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo V Knight

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada

12 MAIDEN NAME OF MOTHER Amelia Chenoweth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Geo V Knight
(Address) 1327½ N Fulton ave

15 Filed , 19 ROBERT R. KRAUTER, Registrar

OCT 3 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Oct 1, 1923, that I last saw him alive on Sept 30, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Non-closure of Foramen Ovale

(duration) Life yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

, 19 (Address) 2516 Pennsylvania ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct. 3 1923
20 UNDERTAKER	ADDRESS
Henry Schwatka	510 Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D79582

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., / WARD)

2-FULL NAME Baby ~~Daisy~~ Fleet

(a) RESIDENCE NO 128 East St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 22/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry Fleet

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Hilda xxxxxxx

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Johns Hopkins Hospital

15 Filed OCT 3 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Sept~~ Aug 24/23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of nwe born

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) prematurity

(duration) yrs. mos. ds.

(Signed) J. S. H. Pollitzer, M. D.
(Coroner)

9/28/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Returned to Hospital — DATE OF BURIAL 192

20 UNDERTAKER Municipal Board — ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D79583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79583

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S. Sharp St. ST., 22 WARD)

2-FULL NAME Bertha L. Davis.

(a) RESIDENCE NO 505 S. Sharp St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. ... should state ... APPLIES. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles M. Davis.

6 DATE OF BIRTH (month, day, and year) December 24, 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ... Sweden.
(State or country)

PARENTS

10 NAME OF FATHER ------ Johnson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweden.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Andrew Davis. (son)
(Address) 508 S. Hart St.

15 Filed, ... 192... ROBERT R. KRAUTER, Registrar
OCT 3 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.
Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Eisenhardt, M. D.
(Coroner.)

Oct, 2, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Westview Cem

DATE OF BURIAL 10/4 1923

20 UNDERTAKER M. Doyle & Son

ADDRESS E. Lee St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79584

CERTIFICATE OF DEATH.

#6 D79584

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Aiken ST., 9 WARD)

2-FULL NAME Lena Benzel

(a) RESIDENCE NO. 1820 Aiken ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Benzel

6 DATE OF BIRTH (month, day, and year): June 15/1871

7 AGE: Years 52 Months ..... Days ..... If LESS than 1 day, hrs. ..... or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Metzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lina Metzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Henry Benzel

(Address): 1820 Aiken St

15 Filed: OCT 3 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31st, 1923, to Sept 30th, 1923, that I last saw her alive on Sept 30th, 1923, and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

about 1 yr. ..... mos. ..... ds.

(duration)

CONTRIBUTORY (Secondary): Asthma

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) L. McCarthy, M. D.

Oct 2, 1923 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: George J. Rutter

ADDRESS: 1735 Harford Ave.

Spec. D79585 1500 Bks. Hogan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

D79585 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 315 Ellwood Ave ST., 6 WARD)

2-FULL NAME Daniel Hogan

(a) RESIDENCE NO. 315 Ellwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? born in U. S. yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Rossiter

6 DATE OF BIRTH (month, day, and year): Dec 27 1872

7 AGE: Years 51 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Road Repair

(c) Name of employer: City of Balto

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto U.S.

14 Informant (Address): Sarah Hogan 315 N. Ellwood Ave

15 Filed OCT 3 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1923, to Oct 1 1923, that I last saw h alive on Sept 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. Instantaneous mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov. 25

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry F. Cassidy M. D.

10/1. 1923 (Address) 1 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 10/4/1923

20 UNDERTAKER: J. G. Moran — ADDRESS 3000 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79586

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

D79586

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 214 E. 23 St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mazie Jackson

(Residence in Baltimore: No. 214 E. 23 St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH: July (Month) 19 (Day) 23 (Year)

7-AGE: ....yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Jerris E. Jackson

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Marie Adams

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Jackson

(Address) 214 E 23 St

15-

Filed OCT 3 - 1923 192.....

ROBERT H. ..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. Pm. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. Pm. (Inquest, autopsy or inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) John Morrison M. D.
(Coroner.)

Oct 3 1923 (Address) 932 Rolan Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ret Return Cem. DATE OF BURIAL: Oct 3 1923

20-UNDERTAKER: Samuel T Hendley ADDRESS: 518 W Biddle St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79587 129 D79587

D79587

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Creek ST. 23 WARD)

2-FULL NAME Mary Gross

(a) RESIDENCE NO. 1002 Creek ST., 23 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Gross

6 DATE OF BIRTH (month, day, and year): 5/21/1874

7 AGE: Years 49 Months 6 Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Florence Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Wm Gross 1002 Creek st.

15 Filed OCT 3 - 1923 HUBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/1/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/15/ 1923, to 10/1/ 1923, that I last saw her alive on 10/1/ 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic # 6 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Chronic (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopical Examination

(Signed) ..... M. D.

10/1/ 1923 (Address) 908 S Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: Samuel T Hurley

ADDRESS 578 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D79588

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003 D79588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD 13)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. Ellen Ellison.

(a) RESIDENCE NO 622 W. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 1, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House keeper.
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER John F. Ellison.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah E. Stinchcomb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Emma Ellison. (sister)
(Address) Magothy, A.A.Co.Md.

15 Filed OCT 3 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 30, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, struck and knocked down by an automobile while walking along a road. Accidental Death. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Leonhardt M. D. (Coroner.)

Oct, 2, 1923. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Accident at Mountain & Pit neck Rds.
Former or usual residence A. A. Co. Md. Sept. 30, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy Church Cem. DATE OF BURIAL Oct 3 1923

20 UNDERTAKER John F Denny ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state AGE should be stated EXACTLY.

Spec.—1-10-21—M&T—1500 Bks.

Richard B. Ormond - Samuel

D79589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79589
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 9 WARD)

2-FULL NAME Mr R.B. Ormand (Richard)

(a) RESIDENCE NO. 1719 Hope St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Ormond nee Hamlin

6 DATE OF BIRTH (month, day, and year) Oct 31, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	49 yrs	11	2 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General Labor

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER David Ormond

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Highlads

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Son. Wm. Ormond
(Address) 706 E. Preston.

15 Filed OCT 3 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Oct 2nd, 1923, that I last saw h[illegible] alive on Oct 2nd, 1923, and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Perineal abscess; infection of scrotum (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 2 1923

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Monninger, M. D.

2, 1923 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Hanford Rd Cemetery — DATE OF BURIAL: Oct 5, 1923

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 524 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec.—1-10-21—M&T—1500 Bks.

D79590

HEALTH DEPARTMENT—CITY OF BALTIMORE

X65-001

D79590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hospital (St.) 11 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Triplett

(a) RESIDENCE NO. Harrisonville Md. (St.) (Ward) Harrisonville Md

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Sgle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 24-22

7 AGE: Years 1 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oakville Md

PARENTS

10 NAME OF FATHER Lizzie Triplett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Triplett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant: Mother Anna Triplett

(Address) Owings Mills

15 Filed OCT 3 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3-23

17 I HEREBY CERTIFY, That I attended deceased from 9-28-23, to 10-3-23, 19 ,

that I last saw h alive on 10-3-23, 19 ,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows: 1

Symptoms Pneumonia

(duration) yrs. 3? mos ds.

CONTRIBUTORY (Secondary) Toxemia,

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically & Chronic Nephritis

(Signed) Jno. A Symptoms M. D.

, 19 (Address) Jno Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ward's Chapel — DATE OF BURIAL: Oct. 5 1923

20 UNDERTAKER: Jno. R. Heer — ADDRESS: Sykesville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79591

CERTIFICATE OF DEATH.

74-001

D79591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 604 Somerset ST., 5 WARD)

2-FULL NAME William J. Boulden.

(a) RESIDENCE NO. 604 Somerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Boulden

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 63 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Washington Boulden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary A. Boulden

(Address) 604 Somerset St

15 Filed OCT 3 1923 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1923 to Oct 2 1923, that I last saw him alive on Oct 1 1923, and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage & Paralysis of face and legs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Interstitial Nephritis & Hypertension.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

10/2 1923 (Address) 1419 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodberry Cem.

DATE OF BURIAL: Oct 5 1923

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

TO

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79592

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Garrison Avenue ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Reid Johnson

(a) RESIDENCE NO. 4000 Garrison Avenue ST., 15 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? 55 yrs. 5 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Oakford Johnson

6 DATE OF BIRTH (month, day, and year): April-29-1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Florist Business

(c) Name of employer: Samuel Feist & Sons

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Charles Reid Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk, Virginia

12 MAIDEN NAME OF MOTHER: Charlotte Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Mrs. Elizabeth O. Johnson (wife)
(Address) 4000 Garrison Avenue

15 Filed OCT 3 - 1923, 19 ..... Registrar

ROBERT R. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1923, to Oct 2, 1923, that I last saw him alive on Oct 1, 1923, and that death occurred, on the date stated above, at 9.4 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis —
Myocardial Ditis —
Duration Many yrs. mos ds.
Paralysis —

CONTRIBUTORY (Secondary) (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas W. Larmour M. D.

Oct 3, 1923 (Address) 1327 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Oct-4-23

20 UNDERTAKER: [illegible] COUNTRY

F. WOODEN, Successor

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Bks.

D79593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79593

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 Robert ST., 14 WARD)

2-FULL NAME Henry Scott

(a) RESIDENCE NO. 551 Robert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Della Scott

6 DATE OF BIRTH (month, day, and year): Apr 6- 1876

7 AGE: Years 47 Months 5 Days 24 If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wash. D.C.

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant. (Address): Della Scott 551 Robert St

15 Filed OCT 3 - 1923

16 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1st 19 23

17

I HEREBY CERTIFY, That I attended deceased from May 4 19 23 to Oct. 1st 19 23

that I last saw him alive on Oct. 1st 19 23

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Paul Brown, M. D.

10/2/1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn. DATE OF BURIAL: Oct 4 19 23

20 UNDERTAKER: Jas. H. Powers ADDRESS 213 Fremont

Spec.—1-10-21—M&T—1500 Bks. Inf of Wm + Margaret Ernest

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79594

CERTIFICATE OF DEATH.

161-901

D79594

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Linwood ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME unknown

(a) RESIDENCE NO. 912 Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 9/21/23

7 AGE: Years — Months — Days 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Ernest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Landman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address):

15 Filed OCT 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/2/1923

17 I HEREBY CERTIFY, That I attended deceased from 9/30/1923 to 10/2/1923, that I last saw her alive on 10/2/23, 19..., and that death occurred, on the date stated above at 6 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Congenital Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Dean, M. D.

, 19 (Address) 1503 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: OCT 3 19

20 UNDERTAKER: Dept. Wm. H. Woodall

ADDRESS: Commissioner Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 D79595

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE; No. ... ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Foster

(a) RESIDENCE NO. Emerson 15 N Elmwood St

(Usual place of abode) ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emerson

6 DATE OF BIRTH (month, day, and year): Unknown 1875

7 AGE: Years 48. Months — Days — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conveyor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Emerson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Geo.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

Filed Oct 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1923 to Oct 2 1923

that I last saw h alive on Oct 2 1923

and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Manic Depressive Psychosis, Mental Phase

duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. E. Feldmeth M. D.

1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Oct 5 1923

20 UNDERTAKER: Rev. E. J. Conway

ADDRESS: 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79596

92

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Levy Armstrong

(a) Residence No. 514 Durham St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? 17y yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Armstrong

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Adam Dickeison

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Debby Holt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Municipal Hospital Record

(Address)

15- FILED OCT 3-1923 RUBEN R. KRAUTH Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 2, '23

17- I HEREBY CERTIFY, That I attended deceased from September 29, 1923 to October 2, 1923

that I last saw her alive on October 1, 1923

and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiovascular Renal

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10-2-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Oct 4, 1923

20-UNDERTAKER. Mrs R A Elliott

ADDRESS 1725 Ashland Ave

WHITE PENCIL, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79597

D79597

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers America Hospital 4 ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Morgan

(a) RESIDENCE. NO. 746 West Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	7 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank J. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Alice E. Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Alice E Morgan
(Address) 746 W. Balto St

Filed OCT 3 - 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 3, 1923,

that I last saw h alive on Oct 2, 1923,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edw. F. Dorsel, M. D.

, 19 (Address) Res. Physician V & A Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Olivet — Oct 3 23

20 UNDERTAKER — ADDRESS

Harry H. Witzke — 1531 W Lombard

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79598

D79598

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Wallbrook Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wenceslaus Wohuna

(a) RESIDENCE NO. 1926 Wallbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Sept. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	78	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Michael Wohuna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Jos. Joseph Lesche (Address) 1926 Wallbrook Ave

15 Filed OCT 3 - 1923, 19 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1-, 1923, to Oct 1st, 1923.

that I last saw h alive on Sept 30th, 1923

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 15 minutes

CONTRIBUTORY (Secondary) Previous attack + Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? —

What test confirmed diagnosis? Usual + coma

(Signed) L. Turner, M. D.

10-3, 1923 (Address) 2202 E. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Oct 1923

20 UNDERTAKER Martin Fahy & Son — ADDRESS 822 W North

Cor.—1-12-23—M&T—100 Bks.

D79599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79599

CERTIFICATE OF DEATH.

74001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2118 Cambridge ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William I Abbott

(a) RESIDENCE No 2118 Cambridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: John E. Adams

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER: Fredrick I Abbott

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Wilkerson

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant: Alfred Abbott
(Address) Back River

15 Filed OCT 3 1923 Registrar

ROBERT H. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Wm. P. Morton M. D.
(Coroner)

Oct 1, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Oct. 3 1923

20 UNDERTAKER: Lilly & Ziler

ADDRESS: 1103 W. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79600 — 161-001 — D79600

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. old annapolis road ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lester Buffett

(Residence in Baltimore: No. old annapolis Road cherry Hill St.; ....yrs.. ....mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Single

6-DATE OF BIRTH, ...10.... (Month) ....1.... (Day), 1923 (Year)

7-AGE, ...yrs. ....mos. 36 hours ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Lester M. Buffett

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances E. Sowers

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lester M. Buffett

(Address) old Annapolis Rd.

15- cherry Hill

Filed OCT 3 1923, 191.... ROBERT A. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...10.... (Month) ....2.... (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10 1 1923, to 10 2 1923, that I saw h im alive on 9 - 2 1923, and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

6½ Months Gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) T.B. Hall M. D.

10-2..., 1923 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct. 3., 1923

20-UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79601

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 214 N. Belnod Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Roberts

(a) Residence No. 214 N. Belnod Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emanuel Roberts

6-DATE OF BIRTH (month, day and year) Nov. 14-1853

7-AGE. 69 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not known

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14- (Informant) Bertha M. Niebuding

(Address) 214 N. Belnod Ave

15- Filed OCT 3 - 1923, 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 2-1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 1923 to Oct 2 1923

that I last saw h.. alive on Oct 2 1923

and that death occurred, on the date stated above, at 12 08 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Sanes M. D

, 19 (Address) 80 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Cathedral DATE OF BURIAL, 19 23 Oct 39

20-UNDERTAKER. Zinkler & Zinkler ADDRESS Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79602

CERTIFICATE OF DEATH.

31 1

D79602 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Collins

(a) Residence No. 1504 Jefferson st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1907

7-AGE: 16 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Thomas Collins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Sanovia Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Hospital Records

(Address): M. T. H.

15- Filed OCT 3 - 1923, 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 14, 1923 to Oct. 1, 1923

that I last saw her alive on Oct. 1, 1923

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. M. Kelly, M. D

10-1-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cem. DATE OF BURIAL: Oct. 4, 1923

20-UNDERTAKER: Mrs J. L. Locks ADDRESS 1302 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS REQUIRED. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Whalen.

D79603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79603

CERTIFICATE OF DEATH.

X 16-002 17

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. 7

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Whalen

(a) RESIDENCE NO. Joppa Harford Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Whalen

6 DATE OF BIRTH (month, day, and year) Sept 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie Lodenzy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL, (Address) Per ROBERT P. KRAUTER, Burial Permit Clerk

15 Filed OCT 3 - 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1923 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, 19 , to Oct 3, 1923, 19 , that I last saw h— alive on Oct 3, 1923, 19 , and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (secondary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Dysentery (Flexner) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Cultivation of B. dysenteriae

(Signed) Cooper, Joel [illegible] M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Joppa Md

DATE OF BURIAL Oct 1923

20 UNDERTAKER Howard K McComas

ADDRESS Aberdeen Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79604 D79604

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Monument (St.) 19 (Ward)

2-FULL NAME Solomon Kohn

(a) RESIDENCE. NO. 2520 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Kohn

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Dr Kohn

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Dr Kohn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dr Kohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E Balto St

15 Filed OCT 3-1923, 19

ROBERT E. LITTIG, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Oct 2, 1923

that I last saw h alive on Oct 2, 1923

and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following an ulcerative colitis - Cause?

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Bronchio Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidore I. Fry, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave

DATE OF BURIAL: 10/24 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D79605

CERTIFICATE OF DEATH.

129 D79605

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Lipsch.

(a) RESIDENCE. No. 130 N. Ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Harris Lipsch

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 58; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1429 E Balto St

15 Filed OCT 3 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ 18th, 1923, to Oct 2nd, 1923, that I last saw h[illegible] alive on Oct 2nd, 1923, and that death occurred, on the date stated above, at 1 05 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 9 yrs. 3 mos. 18 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis, Arterio Sclerosis

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? Athens.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isidore J. Fox, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 10/4 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1429 E Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79606 D79606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 E Clement St. (ST.) 24 (WARD)

REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C Hart.

(a) RESIDENCE NO. 526 E Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 25 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Duerbeck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George E Hart (Father)

(Address) 526 E Clement St.

15 Filed 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1923 to Oct 1 1923

that I last saw her alive on Sept 30 1923

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH was as follows:

Status Epilepticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 17 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Bruce, M. D.

(Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co.

DATE OF BURIAL 10-4 1923

20 UNDERTAKER E & B Hasle

ADDRESS 1156 E West St

Spec.—1-10-21—M&T—1500 Bks.

D79607

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

D79607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Patapsco ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jos. Eisen

(a) RESIDENCE NO. 1412 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 11-19-1910

7 AGE — Years: 12 — Months: 10 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles J. Eisen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rosa M. Ullmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Rosa M. Eisen

(Address): 1412 Patapsco St

15 Filed OCT 3 1923, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10- 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1923, to Oct 2, 1923, that I last saw h[illegible] alive on Oct 1, 1923, and that death occurred, on the date stated above, at 4.14 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Gorham M. D.

Oct 2 1923 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co.

DATE OF BURIAL: 10-5 1923

20 UNDERTAKER: E & B Hasle 115

ADDRESS: E West St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79608

CERTIFICATE OF DEATH.

D79608

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. Bay View Hospital St. (WARD)

2-FULL NAME Graczia Pappa

(a) RESIDENCE No. 636 W. Saratoga St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Giovanni Pappa

6 DATE OF BIRTH (month, day, and year) 6-15-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Carmello Tumeglla

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Maria Pupura

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Tony Tumealla
(Address) 630 W. Saratoga St

15 Filed ..... 192 ..... Registrar

OCT 3-1923

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries & Shock
Both Legs fractured - Ribs fractured
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Struck by Street Car
(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner)
Oct 3rd, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional data.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 10/1/1923

20 UNDERTAKER George J. Ruth ADDRESS 1720 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

D79609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79609

CERTIFICATE OF DEATH.

99-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 W. Barre St. WARD 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elma. T. Wellsworth

(a) RESIDENCE NO. 1044 W. Barre St., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 1923

7 AGE — Years: C — Months: 2 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: C

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter. H. Wellsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Spessard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Walter. H. Wellsworth 1044 W. Barre St

15 Filed OCT 3 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1923 to Oct 2 1923.

that I last saw h alive on 19...

and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John Emmett, M. D.

(Address) 517 Lexington Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem

DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2178 Pa...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Cor.—1-12-23—M&T—100 Blks.

D79610

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

183 D79610

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 761 W. Franklin St., 17 WARD)

2-FULL NAME Mary Carroll

(a) RESIDENCE NO. 761 W Franklin St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Knox

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Daniel Easton
(Address) 716 Pine

15 Filed ....., 192 .....
Registrar

Robert F. Harrison,
1923 Chief Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in Head

(duration) ..... yrs. a few hrs. mos. ..... ds.

CONTRIBUTORY (Secondary) Accidentally shot herself

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. F. Kinsella, M. D.
(Coroner.)

10-3, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10-4 192 3
20 UNDERTAKER Daniel Easton	ADDRESS 716 Pine

Death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79611 D79611

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH University Hospital REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Cor Lombard & Green ST.) 19 (WARD)

2-FULL NAME Margaret Queen

(a) RESIDENCE NO. 1522 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Dennis Queen.

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50 years.	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER Spencer Roane
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Winnie Warren
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1923, to Oct 2, 1923, that I last saw her alive on Oct 2, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Acute Perforated Gangrenous Appendicitis & Peritonitis (Colon Bacilli)
(Duration) yrs. ... mos 3 ds.
CONTRIBUTORY (Secondary) Surgical Shock.
(duration) yrs. ... mos. 1 hr.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of Oct 2, 1923
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Findings
(Signed) J A Rothrock, M. D.
, 19 (Address) Uni Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10-4-1923
20 UNDERTAKER	ADDRESS 916
Dan'l Gaston	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D79612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79612

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward) 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Horton

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1835

7-AGE. 87 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.
10-NAME OF FATHER. ?
11-BIRTHPLACE OF FATHER (city or town) ? (State or Country).
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

11-(Informant) Municipal Hospital Records
(Address)

13-Filed OCT 3 1923 192 Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 1, 1923

17-I HEREBY CERTIFY, That I attended deceased from March 30 19 23 to October 1 19 23.
that I last saw h... alive on October 1 19 23.
and that death occurred, on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) Claude B Kress M. D.
10-2- , 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn — DATE OF BURIAL. 10-4- 1923

20-UNDERTAKER. David Eyster — ADDRESS 916 Penn

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79613

CERTIFICATE OF DEATH.

D79613

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 26 WARD)

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bridget Barr

(a) RESIDENCE NO. 2204 54 st Phila. Pa ST., (28) WARD Phila Pa.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? 50 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 3 - 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel J. Barr

6 DATE OF BIRTH (month, day, and year): Dec 26, 1853

7 AGE — Years: 69 — Months: 9 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Reed

(Address): Mt Hope - Balto

15 Filed: , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1923, to Oct 3, 1923,

that I last saw h[illegible] alive on Oct 3, 1923,

and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.
(Hemiplegia)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senile degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Fullon P. Iorio, M. D.

, 19 (Address) Wyleau & Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila - Penna

DATE OF BURIAL: Oct 3 1923

20 UNDERTAKER: [illegible] & BROWN COMPANY

ADDRESS: 103 W. [illegible] ST.

Spec.—1-10-21—M&T—1500 Bks.

D79614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79614

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2731 Oak. (St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Hofmann

(a) RESIDENCE NO. 2731 Oak ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Hofmann.

6 DATE OF BIRTH (month, day, and year) Jan 7-1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Foreman of Engines

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Pennsylvania Railroad.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John D. Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sarah E. Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Charles E Hofmann (Address) 221 Huntingdon Ave.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 16 - 1923 to October 2 - 1923, that I last saw him alive on October 2 - 1923, and that death occurred, on the date stated above, at 2:27 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) angina pectoris

(duration) 1 yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland., M. D.

10-2-1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 10 5 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

273 - 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79615 D79615

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2623 Hudson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry S. Krysztofiak

(a) RESIDENCE No. 2623 Hudson ST., WARD 18

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry F. Krysztofiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Frances . Spioch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr . Henry F. Krysztofiak

(Address) 2623 Hudson Street.

15 OCT 3 - 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1923, to October 2, 1923, that I last saw him alive on October 2, 1923, and that death occurred, on the date stated above, at 630 Am.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Rotunda M. D.

10-3 1923 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct. 4 1923

20 UNDERTAKER: John McWeber — ADDRESS: 1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79616

CERTIFICATE OF DEATH.

90 D79616

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, ST., 8 WARD)

2-FULL NAME John [illegible] Lagoski

(a) RESIDENCE NO. 1710 W. Pond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Lagoski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mattie Arke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital Records.

(Address)

15 Filed OCT 3-1923, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1923

17

I HEREBY CERTIFY, That I attended deceased from January 3, 1923. to October 1, 1923.

that I last saw him alive on October 1, 1923,

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

Mitral Stenosis & Insufficiency

Auricular Fibrillation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism (Pulmonary Abdominal ?) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Drane, M. D.

10-2-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal., (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross German Hill Rd — DATE OF BURIAL: Oct 5th 1923

20 UNDERTAKER: Martin Dippel — ADDRESS: 312 S. Conn St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79617

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 754 Bartlett Ave ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel John Crimmins

(a) RESIDENCE. No. 754 Bartlett Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Crimmins

6 DATE OF BIRTH (month, day, and year) August 31st 1868

7 AGE: Years 55; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Crimmins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Margaret Crimmins
(Address) 754 Bartlett Ave

15 Filed Oct 3 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1923 to Sept 30 1923 that I last saw him alive on Sept 30 1923 and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) arterio-Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert L. Heiser M. D.

Oct 2 1923 Address) 1211 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Oct 4th 1923
20 UNDERTAKER	ADDRESS
Leo G. Cook	Northumberland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79618

D79618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Bransby

(a) RESIDENCE NO. 1027 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Hillen Bransby

6 DATE OF BIRTH (month, day, and year): July 9. 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Prop. Cooperage Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Charles E. Bransby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Susana Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19th 1923, to October 2nd 1923, that I last saw him alive on October 1st 1923, and that death occurred, on the date stated above, at 11 50 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Paralysis

(duration) — yrs. 2 mos. 13 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleiber M. D.

10/3, 1923 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address): Mrs. Wm. Thomas 1221 Hanover St.

15 Filed OCT 3 1923, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Oct. 5. 1923

20 UNDERTAKER: Margaret J. Flynn

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79619

D79619

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 182 W. Cross ST., 23 WARD)

2-FULL NAME P. Edward Weamert

(a) RESIDENCE NO. 182 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 10. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Marine Ship Bldg. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Weamert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant (Address) Mrs. Dwyer (Sister) 182 W Cross St

15 Filed OCT 3 1923, 19 Registrar Robert P. Carlson, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Oct 1, 1923, that I last saw h alive on Sept 30, 1923, and that death occurred, on the date stated above, at 6-35 a. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Edward Weamert, M. D.

10 3 1923 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL Oct 4 1923

20 UNDERTAKER Margaret A. Flynn ADDRESS 1111 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79620

CERTIFICATE OF DEATH.

100-501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Valley St., 10 WARD)

2-FULL NAME Eileen A. Landerkin

(a) RESIDENCE NO. 918 Valley ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 26-1922

7 AGE: Years 1 | Months √ | Days — | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work: ...

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Landerkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Mary E. Dempsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore City

14 Informant (Address): James Landerkin 918 Valley St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 27th, 1923, to Oct 2nd, 1923, that I last saw her alive on Oct 2nd, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. McParkin, M. D.

Oct 2, 1923 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 4 1923

20 UNDERTAKER: Geo F. Ruth — ADDRESS: 1730 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79621

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1130 Pinreidel Ave 74 WARD)

2-FULL NAME Caroline Penn

(a) RESIDENCE NO. 1130 Pinreidel Ave WARD 74

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willard Penn

6 DATE OF BIRTH (month, day, and year) — — 1877

7 AGE Years 46 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Blaine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant Mrs Penn

(Address) 1130 Pinreidel Ave

15 Filed OCT 3 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1923 to Oct 1, 1923

that I last saw her alive on Oct 1, 1923

and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Cancelmo M. D.

Oct 3, 1923 (Address) 1644 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

DATE OF BURIAL Oct 4 1923

20 UNDERTAKER J. Tracy Doyle

ADDRESS 2814 Eyler Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-21—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79622

D79622

CERTIFICATE OF DEATH.

×182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier 6 Locust Point. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Seddon.

(a) RESIDENCE NO Dover, England. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	17	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman, 6

(b) General nature of industry, business, or establishment in which employed (or employer) S/S Vas Conia.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dover, England.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mr. Guthrie, (Address) English Consulate.

15 Filed OCT 4 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Drowned September 28, 1923. Body recovered October 1, 1923 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Oct, 3, 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem DATE OF BURIAL Oct. X 192 3

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Medina ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Kapsinas

(a) RESIDENCE NO. 206 S. Medina ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9—23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michal Kapsinas

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Antonina Koryta

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Michal Kapsinas
(Address) 521 Gladden St

15 Filed OCT 4 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1923, to —, 19—, that I last saw h~~e~~r alive on Oct. 2nd, 1923, and that death occurred, on the date stated above, at 8.05 p m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 4 ds.

acidosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. T. Ris, M. D.

Oct 3rd, 1923 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 4 19 23
20 UNDERTAKER Frederick W Ozga	ADDRESS 1432 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D79624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79624

CERTIFICATE OF DEATH.

REGISTERED NO. 99-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Oak ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flonnie Murray Paca

(a) RESIDENCE NO. 2119 Oak St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Philemon Paca 3rd

6 DATE OF BIRTH (month, day, and year): Sept 7-1841

7 AGE: 82 Years 3 Months 26 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none (Wife)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Bayley Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Priscilla Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John P. Paca

(Address) 1624 St Paul St

15 Filed OCT 4 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): ~~September 1941~~ Oct 3-1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Oct 3, 1923, that I last saw h[illegible] alive on Oct 2, 1923, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis and old age

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm H Watson, M. D.

, 19 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 10-5 1923

20 UNDERTAKER: H W Jenkins Sons Co — ADDRESS: Mitchell & Orchard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79625

CERTIFICATE OF DEATH.

D79625

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 538 W. Lafayette Av ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton A. Davis

(Residence in Baltimore: No. 538 W. Lafayette Av. St.; 63 yrs., 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, ~~May~~ June, 1863
(Month) (Day) (Year)

7-AGE, 63 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone repairing
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Benj. Davis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Harriett Nuckles

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. B. Davis

(Address) 538 W. Lafayette Av

15-

Filed....., 191....ROBERT P. KRAUTER,
Registrar.

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) ~~Heart Trouble~~

(Duration) yrs. mos. ds.

(Signed) J. F. Heuisler M. D.
(Coroner.)

Oct. 4, 1912 (Address) 1802 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct. 7, 1912

20-UNDERTAKER David Wendel ADDRESS W. Balto

Spec.—1-10-21—M&T—1500 Bks.

D79626

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-004 D79626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 Saratoga St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Gray

(a) RESIDENCE NO. 637 Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Gray

6 DATE OF BIRTH (month, day, and year): Unk

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Rosa Gray

(Address): 637 Saratoga St.

15 Filed ..... 19.. Registrar

OCT 4 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sep 30 1923 to Oct 3 1923.

that I last saw him alive on Oct 3 1923.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at his home

Did an operation precede death? no Date of —

Was there an autopsy? no Clinical signs

What test confirmed diagnosis?

(Signed) R B Kenyon, M. D.

Oct 3, 1923 (Address) 637 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 10/6 1923

20 UNDERTAKER: Ed H Lewis — ADDRESS: 703 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79627

CERTIFICATE OF DEATH.

REGISTERED NO. 15 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1378 N. Carey (St.) (Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Johnson

(a) RESIDENCE. No. 1378 N. Carey St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Henry Johnson

6 DATE OF BIRTH (month, day, and year) March 1, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country) Hughesville Charles County Md

PARENTS

10 NAME OF FATHER William Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Amelia Green

13 BIRTHPLACE OF MOTHER (city or town) Bryantown (State or country) Charles Co. Md

14 Informant (Address) Wm Henry Johnson 1378 N. Carey St

15 Filed OCT 4 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 2, 1923, that I last saw h[illegible] alive on Oct 2, 1923, and that death occurred, on the date stated above, at 9.58 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Contributory Arterio Sclerosis (duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Diffuse Brain (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Oct 3, 1923 (Address) 120 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Oct 5 1923
20 UNDERTAKER	ADDRESS
Wm H Adams	323 Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79628 D79628

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N Washington ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Eifert

(a) RESIDENCE NO. 1104 N Washington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Eifert

6 DATE OF BIRTH (month, day, and year): Nov 13 1850

7 AGE: Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Eifert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Ranker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Eifert (Address) 1104 N Washington

15 Filed OCT 4 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9 1923 to Oct. 3 1923

that I last saw alive on Oct. 2 1923

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Par. Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical signs

(Signed) Chas. A. Meer M. D.

10/3/23 19 (Address) 408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem DATE OF BURIAL Oct 6 1923

20 UNDERTAKER: John Sellers ADDRESS 208 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79629

CERTIFICATE OF DEATH.

113 · D79629

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6517 Fait Ave. ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Grace Wheeler

(a) RESIDENCE. NO. 6517 Fait Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30, 1923

7 AGE: Years | Months: 5 | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Infant

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edwin Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eva Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edwin Wheeler

(Address) 6517 Fait Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1923, to October 1, 1923, that I last saw h[illegible] alive on October 1, 1923, and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Oct 3, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Oct 4 1923

20 UNDERTAKER: John Ellerich

ADDRESS: 2008 Aliceanna

ROBERT P. KRAUTER

OCT 4 1923

Registrar of Vital Statistics

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79630

1-001

D79630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Deitz

(a) RESIDENCE NO. 1227 N. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8/02 [redacted]

7 AGE: Years 21 Months 4 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frank Deitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hesseland Germany

12 MAIDEN NAME OF MOTHER: Katherine Crafft

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Univ. Hosp. records

(Address)

15 Filed OCT 4 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1923, to Oct 2, 1923, that I last saw h[illegible] alive on Oct 2, 1923, and that death occurred, on the date stated above, at 3 46 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary): General Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Oct 2, 1923

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) D. R. Nemmers Asst. M. D.

Oct. 2, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 10/5 1923

20 UNDERTAKER: Philip Hennig

ADDRESS 201 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79631

CERTIFICATE OF DEATH.

89

D79631

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Tyndale Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel F. Eody.

(a) RESIDENCE NO. 3002 Tyndale Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Eody.

6 DATE OF BIRTH (month, day, and year) Jan 12 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spencer, Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mamie Wagner.

(Address) 3002 Tyndale ave.

15 Filed OCT 4 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1922, to Oct 3, 1923, that I last saw him alive on Oct 1, 1923, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emil J Kunzig M. D.

, 19 (Address) 2700 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wellington M. E. — DATE OF BURIAL Oct 4th 1923

20 UNDERTAKER Lilly & Zeiler — ADDRESS 4008 Wash

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79632

CERTIFICATE OF DEATH.

10 D79632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2674 Dulaney St. 20 WARD)

2-FULL NAME Owen Alferd Burgess

(a) RESIDENCE. No. 2674 Dulaney ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 19-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Alfred P. Burgess

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country) Md

12 MAIDEN NAME OF MOTHER Violet L. Seibert

13 BIRTHPLACE OF MOTHER (city or town) Balto,
(State or country) Md

14 Informant Alfred P. Burgess
(Address) 2674 Dulaney St

15 Filed OCT 4 - 1923 19 ROBERT M. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Oct 3, 1923

that I last saw h[illegible] alive on Oct 3, 1923

and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Nasal Diphtheria

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Asa L Wessels, M. D.

10-4, 1923 (Address) 2565 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: Oct. 4 1923

20 UNDERTAKER: George L. Schwab ADDRESS: 701 Eutaw Pl.

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. If LESS THAN ONE DAY, time should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D79633

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D79633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St.) 22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Williams

(a) RESIDENCE NO. 618 Eiselen st - ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Marr.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unkn.

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE — Years: 27 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unkn

11 BIRTHPLACE OF FATHER (city or town) (State or country): " Md

12 MAIDEN NAME OF MOTHER: Unkn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Md

14 Informant (Address): Bay View Hospital

15 Filed 19 Registrar

OCT 4 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Octob. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1923, to Octob 1, 1923, that I last saw her alive on Octob. 1, 1923, and that death occurred, on the date stated above, at 5 25 p. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of Insane)

Unkn. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lueic Infect. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?: Unkn

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinic & Serology.

(Signed) N. Goldsmith M. D.

10/3/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct 7 1923

20 UNDERTAKER: John H Trader — ADDRESS: 142 Uniform St

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Margaret Anna Rossman)

D79634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D79634

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2621 E Oliver St.; 8 WARD)

2-FULL NAME Anna Margaret Rossman

(a) RESIDENCE. No. 2621 E Oliver St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Rossman Sr.

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: 67 yrs. Months: — Days: — If LESS than 1 day hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Chas Rossman Sr. (Address): Halethorpe Md.

15 Filed OCT 4 1923 Registrar: ROBERT R. KRAUS Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2nd 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1923, to Oct, 1923, that I last saw h[illegible] alive on Oct 2, 1923, and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Van Williams, M. D.

, 19 (Address) 201 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lutheran Immanuel — DATE OF BURIAL: Oct. 6, 1923

20 UNDERTAKER: J. Richard F. Cuskey — ADDRESS: 1108 Guilford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D79635

D79635

CERTIFICATE OF DEATH

161-00

Registered No. C

1 PLACE OF DEATH

City of Baltimore (No. Homewood Hospital 9 St. Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Infant Mitchell

(Residence in Baltimore: No. 3545 Greenmount Ave St.: yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): gingle

6 DATE OF BIRTH: Sept. 27/23 (Month) (Day), 1 (Year)

7 AGE: yrs. mos. 6 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): 3545 Greenmount Ave Balto. Md.

PARENTS

10 NAME OF FATHER: John Mitchell

11 BIRTHPLACE OF FATHER (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Eva G. Fifer

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md.

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva G. Mitchell

(Address) 3545 Greenmount Ave.

15 OCT 4 - 1923

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 3/23 (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27/23, 191, to. Oct. 3/23, 191, that I saw h alive on Oct. 3/23, 191, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Prematurity - 7 months Gestation

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J S H Patterson M. D.

10/4/23 (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Oct 5, 192

20 UNDERTAKER: Richard H Cooley — ADDRESS: H08 Guilford a

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79636

CERTIFICATE OF DEATH.

90 D79636

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 S Durham ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Bornstein

(Residence in Baltimore: No. 7 S Durham St.; 11 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, (Month) May (Day) 5, (Year) 1902

7-AGE. 21 yrs. mos. 28 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Factory

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Heyman Bornstein

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Annie Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Bornstein

(Address) 7 S Durham St

Filed OCT 4 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Oct (Day) 3, (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1923, to Oct 3 1923, that I saw h[im] alive on Oct 3 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis Chronic

Valvular Myocarditis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) yrs. 2 mos. ds.

(Signed) Joseph Schwarz M. D.

Oct 3, 1923 (Address) 1 S Durham St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yr. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 7 S Durham St

19-PLACE OF BURIAL, OR REMOVAL Balto Hebrew Cem DATE OF BURIAL, 10/4, 1923

20-UNDERTAKER S. Levinson & Bro ADDRESS 1127 E Balto St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79637

CERTIFICATE OF DEATH.

D79637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, ST., 1 WARD)

2-FULL NAME Josephine Washington

(a) RESIDENCE NO Annapolis Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. few hours mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A. Washington

6 DATE OF BIRTH (month, day, and year) Mar 29/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warrenton Va.

PARENTS

10 NAME OF FATHER Tom ~~Perrin~~ Pinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warrenton Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm. A. Washington (Address) Annapolis Md

15 Filed OCT 4 - 1923 ROBERT R. KRAUTER, Registrar

~~Burial Permit Issued~~

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Adenoma of Thyroid

(Dispensary diag. only in hosp. a few hrs.) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Patten (Coroner.), M. D.

10/4/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	Oct 4 192 3
20 UNDERTAKER Robt J Turner Sr	ADDRESS 172 N Green

Spec.—1-10-21—MAT—1500 Blks.

D79638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D79638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1016 Rutland ave ST., 7 WARD)

2-FULL NAME Eda Wilkins

(a) RESIDENCE NO. 1016 Rutland ave ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John G. Wilkins, Sr.

6 DATE OF BIRTH (month, day, and year): June 1, 1871

7 AGE — Years: 52 — Months: 4 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles N. Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Christer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: John G. Wilkins, Sr.

(Address): 1016 Rutland

15 Filed OCT 4 1923 19 ROBERT R. KRAUTER Registrar

BURIAL PERMIT (CITY)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1 - 1923, to Oct - 3 - 1923,

that I last saw her alive on Oct - 3 - 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? nr Date of

Was there an autopsy? nr

What test confirmed diagnosis? Urinalysis

(Signed) E. Gill Hall, M. D.

Oct 4 1923 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Oct 6 1923

20 UNDERTAKER: Brooklan & Zirkin — ADDRESS: 1739 Eager

Spec.—1-10-21—M&T—1500 Bks.

D79639 (16 6 13)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Henry Dannenfelser

(a) RESIDENCE NO. 3319 Hudson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Father? Mrs Alice Miller

6 DATE OF BIRTH (month, day, and year) Aug 2, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Dannenfelser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record.

15 Filed OCT 4 - 1923, 19.. ROBERT M. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923., 19.. to Oct 3, 1923. 19.., that I last saw him alive on Oct 3, 1923. 19.., and that death occurred, on the date stated above, at 12 50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, gastric

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept 25

Was there an autopsy? Yes.

What test confirmed diagnosis? Usual pathological.

(Signed) J. L. Rauhut, M. D.

, 19.. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Oct 6 1923

20 UNDERTAKER Grobler & Grobler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79640

D79640

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 70 WARD)

2-FULL NAME Charles Modert.

(a) RESIDENCE NO. 2740 Kinsey Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: of Mrs Robert Cory

6 DATE OF BIRTH (month, day, and year): 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer): +

(c) Name of employer: +

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Jacob Modert.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Minnie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: JOHNS HOPKINS HOSPITAL.

(Address): Record

15 Filed . 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923 19 . to Oct 3 1923 19 .

that I last saw h[illegible] alive on Oct 3, 1923, 19

and that death occurred, on the date stated above, at 8 [illegible] A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 0 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Sill Came, M. D.

10/4, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL: Washington D.C.

DATE OF BURIAL: 10/4 1923

20 UNDERTAKER: Robert Brook & Son

ADDRESS: Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79641

CERTIFICATE OF DEATH.

90 *D79641

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Longmead

(a) RESIDENCE NO. 603 Appleton St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ellen Longmead

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): 011

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed . 19 Robert P. Harrison Registrar Burial Permit Clerk

CT 4 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 19 23

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to October 3, 1923.

that I last saw him alive on October 3, 1923,

and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) exfoliative dermatitis

(duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of. —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harry E. Handley, M. D.

10-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 5 19 23

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79642

CERTIFICATE OF DEATH.

168 D79642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N. Dallas St. ST., 7 WARD)

2-FULL NAME Charles J. Schunck

(a) RESIDENCE NO 1028 N. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Add should be stated EXACTLY. PHYSICIANS, Fold state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Schunck

6 DATE OF BIRTH (month, day, and year) May 26/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Formerly Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Laborerin
(c) Name of employer Broom Works

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER JohnSchunck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Ortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna C. Schunck
(Address) 1028 N. Dallas St.

15 Filed ....., 192 Robert P. Harrison, Registrar

CTA - 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide, Hung Himself by rope to door in bedroom.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Potter, M. D.
(Coroner.)

10/4/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 6 1923
20 UNDERTAKER Henry Hosch Son	ADDRESS 1301 E Eager St

Spec- 12-23-21—E.B.R.S.—400 Bks.

D79643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Igo

(a) Residence No. 708 S. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1849

7-AGE: 74 yrs. mos. ds.

If LESS than 1 day: hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS:

10-NAME OF FATHER: Thomas Igo

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Jane Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Hospital Records

(Address): M. T. H.

15- Filed, OCT 4 1923, 192 Registrar.

Robert P. Harrison, Chief Bureau Records

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 30, '23

17- I HEREBY CERTIFY, That I attended deceased from May 14 1923, to Sept. 30 1923,

that I last saw h. in alive on Sept. 30 1923,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous bronchopneumonia (Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D

10-1-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] DATE OF BURIAL: 10/5 1923

20-UNDERTAKER: John F. McGowan ADDRESS: 318 Eighth St

N. B.—WRITE PLAINLY with pen and ink. Do not use pencil. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79644

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Geo Hodes

(a) RESIDENCE NO. Remove to Asylum from 1501 Gay St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE 66 Years — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Mattress Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER John Hodes

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Helena Griesser

13 BIRTHPLACE OF MOTHER (City or town) Germany

(State or country)

14 Informant (Address)

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-16 . 1923 . to 10-3 . 1923, that I last saw h my alive on 10-3-23, 19 and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Diarrhea, Cholecystitis.

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility. Cause (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Jno Thompkins, M. D.

. 19 (Address) Md Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 10/6 1923

20 UNDERTAKER J. J. Gahagan

ADDRESS 31 N Eutaw

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 4-1923 Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D79645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79645

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 414 E. Preston (St.,) 11 (Ward)

2-FULL NAME John Louis Nies

(a) RESIDENCE (No.) 414 E. Preston (St.,) 11 (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Margaret Nies

6 DATE OF BIRTH (month, day, and year): Jan 24 1866

7 AGE — Years: 57 — Months: 8 — Days: 10 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Wise Bros

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Nies

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Hesperother

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Margaret Nies

(Address): 414 E. Preston St

15 Filed OCT 4 1923, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Oct 3rd, 1923, that I last saw him alive on Sept 27, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Dyspnoea & Pulmonary Collapse

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. B. Saunders, M. D.

Oct 4. 1923 (Address) 219 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hoby Cemetery — DATE OF BURIAL: Oct 6 1923

20 UNDERTAKER: Jos Fowlkes & Sons — ADDRESS: 217 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79646 101-001 D79646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 N. Milton Av ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Deasel

(a) RESIDENCE NO. 1649 N. Milton Av ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Henry Deasel.

6 DATE OF BIRTH (month, day, and year) July 27th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Michael H. Deasel.

(Address) 820 N. Linwood ave

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sep 29, 1923 to Oct. 2, 1923

that I last saw her alive on Oct. 2, 1923

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows: Cardio Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pennington M. D.

10. 3. 23 (Address) Glen Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 5th 1923

20 UNDERTAKER	ADDRESS
Lilly & Geiler	405 N. Wolfe av

OCT 4 1923 Robert F. Harrison, Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79647

CERTIFICATE OF DEATH.

100-006

D79647

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Haynes

(a) RESIDENCE NO. 12 W. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wilson Tegner

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Nettie Nagel

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CT 4-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1923, to Oct. 3, 1923,

that I last saw h[illegible] alive on Oct. 3, 1923,

and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Chorea

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (Terminal) Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude J. Hirst, M. D.

10-4, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 10-5 1923

20 UNDERTAKER Lloyd Easton

ADDRESS [illegible]

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79648

D79648

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 4 WARD)

2-FULL NAME Ellen Louise Varner.

(a) RESIDENCE NO Oella, Md. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~
~~HOUSEWIFE~~
(or) WIFE of Peter L. Varner.

6 DATE OF BIRTH (month, day, and year) June 6, 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	3	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House keeper.
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston, S. C.

PARENTS

10 NAME OF FATHER Jack Dennis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston, S.C.

12 MAIDEN NAME OF MOTHER Mamie Farmer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston, S.C.

14 Informant Vester Colson. (niece)
(Address) Ellicott City, Md.

15 Filed OCT 5 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.
Bichloride of Mercury poisoning.
Accidental Death.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct, 4, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Oella, Md. September 30, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Good Shepherd cem — DATE OF BURIAL Oct 5 1923

20 UNDERTAKER Easton Sons. — ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Hanna/1822 W Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79649

CERTIFICATE OF DEATH.

D79649

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3417 East Fairmount ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander F. Tafel

(a) RESIDENCE No. 3417 East Fairmount ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Marie F. Tafel

6 DATE OF BIRTH (month, day, and year): Mar 18-1851

7 AGE — Years: 72 — Months: 6 — Days: 15 — If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 631

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Paul Tafel

(Address): 3417 E. Fairmount

15 Filed ....., 19.....

Registrar

OCT 5 - 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Oct 3, 1923, that I last saw him alive on Oct 3, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no, Date of

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) M. F. Hanna, M. D.

10.4. 1923 (Address) 1822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 5 1923

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79650

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Sargeant St., 21 WARD)

2-FULL NAME Paul E. Green

(a) RESIDENCE NO. 1201 Sargeant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elma A. Green

6 DATE OF BIRTH (month, day, and year) Dec. 9. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	9	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chicken Shipping Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER David W. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriet E. Bivens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Elma A. Green

(Address) 1201 Sargeant St

15 Filed OCT 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Oct 2 1923

that I last saw h[illegible] alive on Oct 2 1923

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Cont. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clark Smith, M. D.

10/3 1923 (Address) 472 N Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	Oct. 6. 1923
20 UNDERTAKER	ADDRESS
Mr. Mrs. John M. Tenfel & Son	801 N. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D79651

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 P. 001 D79651

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH 520 Jasper St.

CITY OF BALTIMORE (No. ~~Inst. A. Hy~~ ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno. A. Medley

(Residence in Baltimore: No. 520 Jasper St. St.: 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, August ....., 1885
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Geo. Medley

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Emily Butler

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emily Medley

(Address) 520 Jasper St.

15-

Filed OCT 5 1923, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 1, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... was History

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Oct. 3, 1923 (Address) 780 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Oct. 3, 1923
20-UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1722 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Max Kalus)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79652

CERTIFICATE OF DEATH.

D79652

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. ST. 27 WARD)

2-FULL NAME Max Kalus

(a) RESIDENCE NO. 4943 Drumor Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Kalus

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Leonard Kalus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Baily Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Leurs 1439 E Baltimore St

15 Filed OCT 5 - 1923 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1923, to Oct. 4, 1923, that I last saw him alive on Oct 4, 1923, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (streptococci)

Septicaemia (")

(duration) yrs. mos. 2 ds.?

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of Sept. 5, 1923 (mastoid operation)

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidor I. Jay, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 10/5 1923

20 UNDERTAKER Jack Leurs ADDRESS 1439 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mat Wolfson

D79653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79653

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: No. Monument ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark Wolfson.

(a) RESIDENCE. NO. 1009 E. Fairmount Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ephrion Wolfson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gertie Wolfson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs

(Address) 1439 E. Baltimore St

15 Filed ——, 19—— Registrar

OCT 5 1923

ROBERT R. KRAUTER, Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Oct 4, 1923, that I last saw h[illegible] alive on Oct 4, 1923, and that death occurred, on the date stated above, at 11.55 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis Heart & Kidney Disease with Bronchio Pneumonia - Pleurisy - Pulmonary Edema -

(Acute) 3 mos (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy - Br. Pneumonia for 2 days (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes - Partial

What test confirmed diagnosis? General findings

(Signed) [illegible] M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 10/5 1923

20 UNDERTAKER Jack Leurs

ADDRESS 1439 E Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Nephritis

Spec.—1-10-21—M&T—1500 Bks.

D79654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Brososke

(a) RESIDENCE NO. 1045 Ridgely St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 47; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: E. Brososke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Frederica Fürlicher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records

(Address)

15 Filed OCT 4 1923 19 — Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 4, 1923, that I last saw him alive on Oct 4, 1923, and that death occurred, on the date stated above, at 10 45 Am.

The CAUSE OF DEATH* was as follows:

Acute perforated duodenal ulcer with diffuse peritonitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 4/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Frank D. Lynn M. D.

, 19 (Address) 41 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Oct 6 1923

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D-79655 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D-79655

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Frederick Ave ST.) 20 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Tibbe

(a) RESIDENCE. NO. 3142 Frederick Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Tibbe

6 DATE OF BIRTH (month, day, and year) Aug 25 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick H. Tibbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward H. Tibbe

(Address) 3142 Frederick Ave

15 Filed Registrar

OCT 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to Oct 4, 1923,

that I last saw him alive on Oct 3, 1923,

and that death occurred, on the date stated above, at 6 15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Chr. Interstitial Nephritis. Cystoscopic Examination

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Noble, M. D.

10/5, 1923 (Address) 2157 Hilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct. 8 1923

20 UNDERTAKER: C. W. Dill. — ADDRESS: 3109 Frederick Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D-79656 HEALTH DEPARTMENT—CITY OF BALTIMORE D-79656

CERTIFICATE OF DEATH.

175-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 N. Rose St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Stuebe

(a) Residence No. 604 N. Rose St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Hedwig Stuebe

6-DATE OF BIRTH (month, day and year): July 15, 1852

7-AGE: 71 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or mio.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hess Brothers

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Hedwig Stuebe

(Address) 604 N. Rose St.

15- Filed OCT 5 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 - 1923 to Oct 2 - 1923

that I last saw h— alive on Oct - 2 - 1923,

and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Infection Left - following Fract - Spine - 40 yr. Cancer paralysis of lower extremities - resulting — bed sore (Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion — (Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? - 40 yr. Front Porch

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) [illegible] M. D

Oct 5 - 1923 (Address) 125 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 5, 1923

20-UNDERTAKER: H. Sanders Sons — ADDRESS: 1708 Fleet St.

N. B.—WHITE PLANET, WITH BINDING MARGIN, EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79657

CERTIFICATE OF DEATH.

91-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hosp. (St.) K (WARD)

2-FULL NAME Thomas Moulton.

(a) RESIDENCE No. 113 W Franklin St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thos Moulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Phila Robson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Relative

(Address)

15 Filed OCT 5 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 . 3 . 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-1-23 19 . to 10-3-23 19 .

that I last saw h alive on 10-3-23 19 ,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy of heart 7

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation at Forest

DATE OF BURIAL Oct 5 1923

20 UNDERTAKER Harry A. Wilhe

ADDRESS 1603 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT R. KRAUTER, Burial Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Bks.

D79658 HEALTH DEPARTMENT—CITY OF BALTIMORE D79658

CERTIFICATE OF DEATH. 179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1311 Aisquith ST., 9 WARD)

2-FULL NAME Sally Phelps 1311 Aisquith St

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 29, 1846

7 AGE: Years 77 | Months | Days | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Practical nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 048
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS
10 NAME OF FATHER: John Phelps.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia. Va.
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia. Va.

14 Informant (Address): 1311 Aisquith st Mrs. S. E. Cannon

15 Filed OCT 5 1923 H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1923 to Oct 4 1923.
that I last saw h alive on Oct 4 1923
and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.
(right hemiplegia)
(Duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Chr. nephritis. Hypertension arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None save urinalysis & blood pressure readings
(Signed) George Abner Bowden M. D.
10/4, 1923 (Address) 1176 North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery. DATE OF BURIAL: Oct. 5 1923

20 UNDERTAKER: George. J. Roth ADDRESS: 1785 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

D79659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D79659

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1436 E. Fayette ST. 5 WARD)

2-FULL NAME John H. Corbett

(a) RESIDENCE NO. 1436 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 43 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Charles Corbett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lizzie M. McCallister

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Ella Corbett 1436 E. Fayette St

15 Filed OCT 5 - 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/3 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-30, 1923, to 10-2-, 1923, that I last saw h in alive on 10-2-, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Incipient Tuberculosis

CONTRIBUTORY (Secondary) Pleurisy with Effusion (duration) yrs. mos. 14 ds. 5

18 Where was disease contracted if not at place of death? Dont know.

Did an operation precede death? no Date of —

Was there an autopsy? none

What test confirmed diagnosis? Physical Examination

(Signed) Solomon C. Katzoff, M. D.

(Address) 116 Courtland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Oct 5 1923

20 UNDERTAKER: A. Levinson & Bro — ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10,21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79660

CERTIFICATE OF DEATH.

D79660

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ... ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Rucci

(a) RESIDENCE NO. 906 E. Pratt St. ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 14 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of— (or) WIFE of Antonia Rucci

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) ... (State or country) Italy.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record

15 Filed ... , 19 ... ROBERT R. KRAUSER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923 to Oct 3 1923

that I last saw her alive on Oct 3, 1923

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Tubal Pregnancy.
Pelvic Hematocele Infected.
Fibrinous Peritoneal Adhesions.

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) Post-operative Enteritis & Obstruction

(duration) yrs. ... mos. 24 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of 9-6-23. 9-10-23.

Was there an autopsy? no.

What test confirmed diagnosis? Path. Exam of Operative Specimen

(Signed) George R. Gardner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent's — DATE OF BURIAL Oct 6 1923

20 UNDERTAKER Wendell Duffy & Son — ADDRESS 3708 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79661

CERTIFICATE OF DEATH.

113 D79661

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 912 Homewood Ave ST., 10 WARD)

2-FULL NAME Ernst Harris

(a) RESIDENCE NO 912 Homewood ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 3/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Harri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Lockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ada Lockett
(Address) 912 Homewood Ave

15 Filed OCT 5 - 1923, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3/1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion

(continous diarrhea)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Dentition

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Culler, M. D.
(Coroner)

10/5/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-5-23, 192

20 UNDERTAKER David Fenton

ADDRESS 916 Ea ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D79662 — 90

1-PLACE OF DEATH: 2407 W. North ave — REGISTERED NO. D79662

CITY OF BALTIMORE (No. Mrs Elizabeth Beaver St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2407 W. North ave St.; 60 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (If rite the word): Widow

6-DATE OF BIRTH: ——— (Month) (Day) , 1827 (Year)

7-AGE: 93 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Just Kruber

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Just Kruber

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs I. Thomas

(Address) 2407 W. North Ave

15- OCT 5 - 1923 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 3rd (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1923. to Oct 3rd 1923

that I saw her alive on Oct 2, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Duration yrs. mos. ds

Contributory (SECONDARY) Chronic Myocardial Insufficiency

(Duration) yrs. mos. 16 ds.

(Signed) G Carroll Lockard M. D.

Oct 5, 1923 (Address) 4 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Co — DATE OF BURIAL: Oct 6 1923

20-UNDERTAKER: David Easton — ADDRESS: 916 Penna

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79663

CERTIFICATE OF DEATH.

X 153 D79663

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred. Nelson

(a) RESIDENCE NO. Sykesville Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec 12 1901

7 AGE — Years: 21 — Months: 9 — Days: 23 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer, gen

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: L. M. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Francis Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant: L. M. Nelson

(Address): Sykesville Md

15 Filed ....., 19 .....

ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-6-19

17 I HEREBY CERTIFY, That I attended deceased from 10-1-23, 19 ..., to 10-6-23, 19 ...,

that I last saw him alive on 10-6-23, 19 ...,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis of face.

(duration) yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Contusion face, (duration) very much. yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) ..... M. D.

, 19 ... (Address) Md Sykesville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sykesville, Md

DATE OF BURIAL: ..... 19 ...

20 UNDERTAKER: Jas. J. Weaver

ADDRESS: .....

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Investigated by Coroner
Autopsy performed
Chronic Contusion Cerebrum
at
No other history.

D79664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79664

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie E. Hall

(Residence in Baltimore: No. 5135 Park Heights Ave. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. unknown (Month) (Day) 1858 (Year)

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dress maker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country). Dorchester County Maryland

PARENTS.

10-NAME OF FATHER, Francis A. Hall

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Adeline Evans

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary V. Hill

(Address) 1823 N. Payson St.

15- Filed OCT 5 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, October (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

First Cau
Fracture of Skull
Shock

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) ds.

(Signed) G. O. Gladd M. D. (Coroner.)

10-4 1923 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem	Oct 6th 1923
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 W. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D79665

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital St., 70 WARD)

2-FULL NAME George W. Carter

(a) RESIDENCE No. 520½ Poplar Grove ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Virginia L. Carter

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer and Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer (self)

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER John H. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *

14 Informant Mrs. Virginia Carter

(Address) 520½ Poplar Grove St.

15 Filed OCT 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octob. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1923, to Octob. 3, 1923, that I last saw him alive on Octob. 3, 1923, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Myocardial Exhaustion
Chronic Nephritis
Uraemia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uraemia.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Harry E. Handley, M. D.

10-5 1923 (Address) Mammoral Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 6 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D79666

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 238 Loudon Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Ann Fitzsimmons

(a) Residence No. 238 Loudon Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write one word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Fitzsimmons

6-DATE OF BIRTH (month, day and year) June 9 1862

7-AGE. 61 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS:

10-NAME OF FATHER, Patrick Faherty

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Barbara Noon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Miss Elizabeth Fitzsimmons

(Address) 238 Loudon Ave.

15- Filed 192 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 3rd 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923 to Oct 3, 1923

that I last saw her alive on Oct 3, 1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Glands of Neck & Mediastinum

6

(Duration) yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

Oct 3 1923 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem	Oct 6 1923

20-UNDERTAKER.	ADDRESS.
Joseph B Cook	1003 N Balto St

AUG 5 1923

INSTRUCTIONS—PHYSICIANS AND UNDERTAKERS. Every question should be carefully answered. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 V

D79667

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.....St., Municipal Tuberculosis Hospital 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Doetzer

(a) Residence No. 3765 Morley st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Unknown~~ 20 yrs. 4 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1903 May 12

7-AGE. 20 yrs. 4 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Nurse

(b) General nature of industry, business, or establishment in which employed (or employer). Hospital

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John Doetzer

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Carrie Crouse

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed OCT 5 - 1923 19.. ROBERT H. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 12, 1923 to Oct. 4 1923

that I last saw her alive on Oct. 4 1923

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally, M. D

10-4-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem

DATE OF BURIAL. Oct 6 to ....., 1923

20-UNDERTAKER. Lilly & Zeller

ADDRESS 4003 Wolfe St.

N. B.—WHITE PLAINLY, WITH INDELIBLE INK. THIS IS A LEGAL RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79668 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D79668

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH Hebrew Hospital 14 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument & Rutland ST., WARD)

2-FULL NAME Mrs. Hannah Morris

(a) RESIDENCE No. 517 Sanford Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. Morris

6 DATE OF BIRTH (month, day, and year) May 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	59	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Bugass.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Sarback

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Louis Morris
(Address) 512 Sanford Pl.

15 Filed , 19 Registrar

CT 5-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 , 1923 . to Oct 5 , 1923 .

that I last saw h alive on Oct 5 , 1923 ,

and that death occurred, on the date stated above, at 7 35 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

8 hours
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gumma of intestines
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Fuller Jos. Sommer, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 10/ 1923

20 UNDERTAKER David Sondheim ADDRESS 918 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79669 D79669

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 930 N. Vincent St. 16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chesley

(a) RESIDENCE NO. 930 N Vincent St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj. M. Chesley

11 BIRTHPLACE OF FATHER (city or town) Charles Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. (State or country) Maryland

14 Informant Mary Chesley (Mother)

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Oct 4, 1923, that I last saw her alive on Oct 3, 1923 and that death occurred, on the date stated above, at 12:30 A m

The CAUSE OF DEATH* was as follows:

Prematurity (30 weeks fetus).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Robert P. Barrison, Commissioner Health

Wm. H. Wessels, Clerk

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

207 5-1923

Cor.—1-12-23—M&T—100 Bks.

D79670 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D79670

182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Cor 5 Hall St. (Ward)

2-FULL NAME Ed. Hall

(a) RESIDENCE NO. Same St., WARD Same

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Same

6 DATE OF BIRTH (month, day, and year) Same

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45 about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Same (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed OCT 5 - 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned in Creek from Pile Driver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. Riley, M. D. (Coroner.)

Oct 2, 192 3 (Address) 1629 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State Same yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 2 192 3

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1400 M&T—1500 Blks.

1664 10

D79671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79671

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 20 WARD)

2-FULL NAME Bernhard Schultz

(a) RESIDENCE NO. 2030 W. Pratt St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Dorothea~~ Roney Hoffman

6 DATE OF BIRTH (month, day, and year) Nov 5, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record

15 Filed OCT 5 1923, 19 Robert P. Garrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept 15, 1923~~ 19 to Oct 4, 1923 19, that I last saw him alive on Oct 4, 1923 19, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency. Chronic Cardiac valvular disease. Arteriosclerosis

(duration) 3 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary infarct Broncho pneumonia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Still Carey, M. D.

10/4, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct. 6 1923

20 UNDERTAKER George L. Schwab — ADDRESS 2101 Beck. Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16316 D79672 — 159-01 D79672

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 21 WARD)

2-FULL NAME Oliver Engle.

(a) RESIDENCE No. 2141 W. Saratoga St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Adel~~ Elmer

6 DATE OF BIRTH (month, day, and year): June 11, 1923.

7 AGE — Years: — Months: 3 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Elmer Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Blanche Lippard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital Record

15 Filed OCT 5 1923, 19 — Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923 19 to Oct 5, 1923 19, that I last saw him alive on Oct 5, 1923, 19, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Secondary Internal Hydrocephalus

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) Birth Pneumonia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bagley M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Oct 6th 1923

20 UNDERTAKER: J J Cowan per F J Cowan — ADDRESS: 901 Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

D79673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79673

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 328 E 22nd St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Milton Hendrix

(a) Residence No. 328 E 22 St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	White	Married

5a-If married, widowed, or divorced—HUSBAND of (or) WIFE of Sally S Hendrix

6-DATE OF BIRTH (month, day and year) Oct 13 63

7-AGE. 59 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)... K of P

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Pa

PARENTS.

10-NAME OF FATHER, Thomas H Hendrix

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Rebecca Austine

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Pa.

11- (Informant) Mrs Sally Hendrix

(Address)..... 328 E 22 St

13- Filed ..... 1923 ..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1923 to Oct 4 1923

that I last saw h. alive on Oct 4 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tumor Cerebral

(Duration)..2.. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Failure

(Duration)..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)..... W Travers M. D.

Oct 5, 1923 (Address) 1228 Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Stewartstown Pa	Oct 8, 1923
20-UNDERTAKER.	ADDRESS
W M Rowlson	2258 W Balto

Robert F. Harrison, Burial Permit Clerk.

OCT 5 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D79674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79674

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 101 E Virginia Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Bell Rodkey

(a) Residence No... 101 E Virginia Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
F	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Rodkey

6-DATE OF BIRTH (month, day and year) July 23 79

7-AGE. 42 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Carroll Co Md.

PARENTS.

10-NAME OF FATHER, Charles Stevenson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Carroll Co Md.

12-MAIDEN NAME OF MOTHER, Catherine Roberts

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

11- (Informant) Charles Rodkey

(Address) 5134 Park Heights

15- Filed ..... 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 4-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1922 to Oct 4 1923, that I last saw h[illegible] alive on Oct 3 1923, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

1 Arterio-sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical

(Signed) J. C. Brumbach M. D.

105 19 (Address) 1531 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Interment	Oct 6 1923
20-UNDERTAKER. W M Routson	ADDRESS 2235 N Arlington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 5 1923

D79675

D79675

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 S Bunney ST. 1 WARD)

2-FULL NAME Helen Ptaszynski

(a) RESIDENCE. NO. 1119 S Bunney ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Mar 14 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Walter Ptaszynski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Agnes Maliszewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Walter Ptaszynski
(Address) 1119 S Bunney St

15 Filed ..., 19

Roberts P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2nd, 1923, to Oct. 5th, 1923, that I last saw her alive on ..., 1923, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Entero - colitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Kramer, M. D.

10 5, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Oct 6 19 23
20 UNDERTAKER	ADDRESS
[illegible]	

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79676

D79676

CERTIFICATE OF DEATH.

182 4

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Pier No. 5 Pratt St. ST., WARD)

2-FULL NAME Robert C. Barnes.

(a) RESIDENCE No 640 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 23. 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Charles G. Barnes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Leah Hufsmuth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Mrs. George Soulke. (sister)
(Address) 7 Linden Ave. Merchantsville, N.J.

15 Filed OCT 5 - 1923 192 Robert F. Harrison Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found October 3, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (M. D.)
(Coroner.)

Oct, 5 . 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 6 1923

20 UNDERTAKER John C. Mitchell ADDRESS 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D79677 REGISTERED NO. Oct 6/23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 10 WARD)

2-FULL NAME Ellen Mc Call

(a) RESIDENCE NO. 837 E. Eager ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Owen McCall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt. Manfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. M. McCourt 625 E. Chase St

15 Filed OCT 6 - 1923, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Oct 3, 1923, that I last saw her alive on Oct 3, 1923, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

~~First~~

Myocardial insufficiency

Hypostatic pulmonia (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Fracture neck of right femur (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 837 E. Eager St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical evidence.

(Signed) Geo. B. Egbert, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Oct 6 1923

20 UNDERTAKER: H. C. Windfeld — ADDRESS: 914 Gruenmt Ave

Spec.—1-10-21—M&T—1500 Bks.

D79678 HEALTH DEPARTMENT—CITY OF BALTIMORE 162 D79678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — High Lanbard

CITY OF BALTIMORE; (No. 40 N. Eleventh ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of John H. & Helen Matthews

(a) RESIDENCE NO. 40 N. Eleventh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER John H. Matthews

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Helen Kupfer

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Mrs. John H. Matthews (Address) 40 N. Eleventh St

15 Filed OCT 6 1923, 19 Robert P. Harrison, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th, 19 23, to Oct 5th, 19 23,

that I last saw h alive on Oct 5th, 19 23,

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 6 19 23

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1331 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79679 ✓ 10 D79679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 332 Delaware Ave St., 27 Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number.)

2-FULL NAME Glyndon T. Duvall

(a) Residence No. 332 Delaware Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 7 1922

7-AGE. 1 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry H Duvall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Ingrid M Shaw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Harry H Duvall

(Address) 332 Delaware Ave

15- Filed ..... 192.....

Registrar.

OCT 6 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1923 to Oct 5 1923

that I last saw him alive on Oct 5 1923

and that death occurred, on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria (Croup)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D

Oct 6 1923 (Address) 1929 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL. Oct 6 1923

20-UNDERTAKER. George Gehnrich

ADDRESS 1532 Hollins Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Nasal

Spec.—1-10-21—M&T—1500 Bks.

D79680

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79680

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) III S. Poppleton (St.,) 18 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Franklin Pedrick

(a) RESIDENCE NO. III S. Poppleton ST., ... WARD .....

(Usual place of abode) Life

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Martha V. Pedrick

6 DATE OF BIRTH (month, day, and year) July 15, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Locomoive R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joshua V. Pedrick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Susan Lehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Elsie Barnes (Address) 112 Columbia Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923, to Oct 4, 1923, that I last saw him alive on Sept 30, 1923, and that death occurred, on the date stated above, at 9.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart-disease

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy L. Phillips M. D.

Oct 6, 1923 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Oct 6 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 153 W Lombard

Spec- 12-23-21- E.B.R.S.—400 Bks.

D79681 HEALTH DEPARTMENT—CITY OF BALTIMORE D79681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Cole

(a) Residence No. 1623 N. Calhoun st. St., Ward.
(Usual place of abode) Above
(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Cole

6-DATE OF BIRTH (month, day and year) 1859

7-AGE.	If LESS than 1 day.
64 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Stephen Cole

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Hospital Records
(Address): M.T.H.

15- Filed OCT 8 1923 192 Registrar. Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 18 1922 to Oct. 4 1923

that I last saw him alive on Oct. 4 1923

and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. C. Kelly M. D. M. D.

10-4-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral DATE OF BURIAL: Oct 8th 1923

20-UNDERTAKER: Thomas Kilroy ADDRESS 1364 W Cary

WHILE ENTIRE, WITH ONE BLANK, THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D79682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79682

CERTIFICATE OF DEATH.

1 X 124

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mamie Solomon

(a) Residence No. Brunswick Md St., Ward Brunswick Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Solomon

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9-BIRTHPLACE (city or town) Md
(State or Country)

PARENTS.

10-NAME OF FATHER Patrick Burns.

11-BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)

12-MAIDEN NAME OF MOTHER, Ellen Fitzpatrick

13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14-

(Informant) Hospital Records

(Address)

15-

Filed ..... 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/5/27.

17- I HEREBY CERTIFY, That I attended deceased from 9/4/27, 19..... to 10/5/27, 19.....

that I last saw h. alive on 10/5/27 19..... P.

and that death occurred, on the date stated above, at 2.25 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency; Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism Cardiac Decompensation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) K. W. Foley M. D

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Brunswick	Oct. 8, 1927
20-UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Main Boyds Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 6 - 1927 Robert P. Harrison, Registrar

Spec.—8-24-14—M. & T.—2000 Bks.

NORWOOD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79683

CERTIFICATE OF DEATH.

113 D79683

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2018 Ellsworth ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Ernest Ingram~~ Leonard Ingram Norwood.

(Residence in Baltimore: No. 2018 Ellsworth St.; ....yrs., 10 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH 28th November, 1922
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. 10 mos. 7 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert Taylor Norwood

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Sadie E. Zabel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert T. Norwood

(Address) 2018 Ellsworth St.

15-

Filed ..... 191.....

OCT 6 - 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5th, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30th 1923, to Oct 5th 1923, that I saw h.m alive on Oct 5th 1923, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

.....Ileo Colitis.....

.....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) P. McCarthy Wharton M. D.

Oct 5th, 1923 (Address) 3005 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery — DATE OF BURIAL, Oct. 6, 1923

20-UNDERTAKER Henry Lutz — ADDRESS 1203 N Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D79684

HEALTH DEPARTMENT--CITY OF BALTIMORE

D79684

CERTIFICATE OF DEATH

128

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1413 Penna Ave ST. 14 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Bradshaw

(Residence in Baltimore: No. 1413 Penna Ave St.: 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Not Known, 1878 (Month) (Day) (Year)

7 AGE: 45 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Saleeman
(b) General nature of industry, business, or establishment in which employed (or employer): self

9 BIRTHPLACE (State or country): N.C.

PARENTS

10 NAME OF FATHER: John Bradshaw

11 BIRTHPLACE OF FATHER (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Jemis Bradshaw

13 BIRTHPLACE OF MOTHER (State or country): N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dallas C. Barber

(Address) Philadelphia, Pa.

15

Filed .191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 3 (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923 to Oct 3 1923

that I saw him alive on Oct 3, 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Uremic Coma

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Acute Interstitial Nephritis (Duration) yrs. mos. 8 ds.

(Signed) J. L. Hamilton M. D.

Oct 5, 1923 (Address) 302 D Dallas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetary

DATE OF BURIAL: Oct. 6" 1923

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1309 Druid Hill Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

D79685 HEALTH DEPARTMENT—CITY OF BALTIMORE D79685

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Baker st ST.: 15 WARD)

2-FULL NAME Lydia Hoy

(a) RESIDENCE. NO. 1704 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias Hoy

6 DATE OF BIRTH (month, day, and year) 3-10-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Kitty Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Sara L. Hoy
(Address) 1704 Baker St.

15 Filed OCT 6 1923, 19 Robert P. Harrison, Registrar
Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-2- , 1923, to 10-5- , 1923, that I last saw h er alive on 10-5- , 1923, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows: Cardio-Renal Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Church Cem. Long Green Md.	10-7 1923
20 UNDERTAKER George T. A. Gibson	ADDRESS 838 Fawn St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79686 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 79686

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Gen'l Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes Ruth Stanley

(a) RESIDENCE NO. 1304 Mt Royal Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Stanley

6 DATE OF BIRTH (month, day, and year): Dec 19, 1891

7 AGE: Years 31 Months 9 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Wm. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Agnes Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): John W. Stanley 1304 Mt Royal Ave

15 Filed ..... 19 Registrar: Robert P. Harrison,

OCT 6 1923

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Oct 6, 1923, that I last saw her alive on Oct 6, 1923, and that death occurred, on the date stated above, at 12 35 A m.

The CAUSE OF DEATH* was as follows:

Acute Salpingitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Sept 20

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs + Symptoms

(Signed) H. C. Warlick M. D.

19 (Address) S. Balto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Port Md

DATE OF BURIAL: Oct 7 1923

UNDERTAKER: John Oldefield

ADDRESS: 1201 W. Baltimore St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

~~Acute~~ Pneumococcus
Infection

Spec.—1-10-21—M&T—1500 Bks.

D. 79687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 / D 79687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Green

(a) RESIDENCE NO. White Hall Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 1 hr

Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Francis Green

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Amanda Wilson

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Mother (Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4 , 1923, to Oct 4 , 1923, that I last saw him alive on Oct 4 , 1923, and that death occurred, on the date stated above, at 8:40 a m.

The CAUSE OF DEATH* was as follows:

congenital weakness + atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Wallace Walker M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 6 1923

Commissioner of Health

Deputy Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-26

Spec.—1-10-21—M&T—1500 Bks.

D 79688

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79688

CERTIFICATE OF DEATH.

161-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) N. 110 Carrollton Ave ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jackson

(a) RESIDENCE NO. 11 N Carrollton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 3 1923

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Sam Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Waynesboro South Carolina

12 MAIDEN NAME OF MOTHER: Lucille Tait

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Waynesboro South Carolina

14 Informant: Mother

(Address): 18 Carlton St

15 Filed ..., 19 ... Registrar

Robert P. Harrison, Burial Permit Clerk

OCT 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1923, to Oct 4, 1923, that I last saw h[illegible] alive on Oct 3 1923 and that death occurred, on the date stated above, at 7 AM

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adolphus Reese M. D.

10/5 1923 (Address) University Hosp. 1-1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem — DATE OF BURIAL: Oct 5 1923

20 UNDERTAKER: Brown Leland & Schwaab — ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79689

CERTIFICATE OF DEATH.

X 135 D 79689

1-PLACE OF DEATH University Hosp 4

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Matthew McCafferty

(a) RESIDENCE NO. Elliott City ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Margaret McCafferty

6 DATE OF BIRTH (month, day, and year): 1848

7 AGE: Years 75 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Wm McCafferty Maryland

PARENTS

10 NAME OF FATHER: Wm McCafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Meredith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Hosp Records

15 Filed OCT 6 1923 19..... Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-24- 1923 to 10-5- 1923

that I last saw him alive on 10-5- 1923

and that death occurred, on the date stated above, at 10 55 A.m.

The CAUSE OF DEATH* was as follows:

acute suppression of urine

myocardial insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): chronic benign hyper trophy of prostate

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 9-26-23 10-2-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. Dorsey Coale, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Johns Cem

DATE OF BURIAL: Oct 7 1923

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79690

D 79690

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Russell St. ST. Mt. Winans WARD

2-FULL NAME Emma Brown

(a) RESIDENCE NO. Russell St. ST. Mt. Winans WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1902

7 AGE Years 21 Months 2 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bolton Md

PARENTS

10 NAME OF FATHER Amos Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Brown

(Address) Mt. Winans

15 Filed OCT 6 1923, 19

Registrar Robert T. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/21/ 1923 to 10/4/ 1923

that I last saw h alive on 10/4/ 1923 8 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. B. Hamilton, M. D.

10/5, 1923 (Address) 912 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 10/7 1923

20 UNDERTAKER Jas Keenan ADDRESS 1313 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79691

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Riggs Av. ST., 16 WARD)

2-FULL NAME Nelson Hopkins

(a) RESIDENCE NO. 1428 Riggs Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Hopkins (deceased)

6 DATE OF BIRTH (month, day, and year) Not known 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) North Carolina

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N. C.

12 MAIDEN NAME OF MOTHER Abbie Shines

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N. C.

14 Informant James E. Hopkins (Address) 1428 Riggs Av.

15 Filed ..... 19 ..... Registrar

OCT 6 1923 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30 - , 1923 , to Oct 5 - , 1923 , that I last saw him alive on Oct. 4 - , 1923 , and that death occurred, on the date stated above, at 10-30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Theo. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson M. E. | DATE OF BURIAL 10/6 1923

20 UNDERTAKER Jos. N. Deems & Brother | ADDRESS 1213

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 79692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 79692

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 E. Pratt ST.: E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna F. Sherman (Adelman)

(a) RESIDENCE. No. 1831 E. Pratt St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mat Sherman

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Levin 1439 E. Balto.

15 Filed . 19 Registrar

ROBERT R. KRAUTER

OCT 7 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 5, 1923, that I last saw her alive on Oct 5, 1923, and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis;
Myocardial degeneration

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leon Ginsburg, M. D.

, 19 (Address) 1906 Jackson Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Antrim Cem.	Oct. 7- 1923

20 UNDERTAKER ADDRESS

East Lewis, 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wolf.

D 79693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79693

CERTIFICATE OF DEATH.

1704

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2004 Brookfield Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raphael Wolf

(Residence in Baltimore: No. 2004 Brookfield Ave St.; yrs. 38 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1866 (Year)

7-AGE. 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): ..... D 5

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis .....

(Address) 1439 Bank

15- Filed OCT 7 - 1923 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct (Month) 6 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Chronic Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

1923 (Address) 1432 Robert

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Hebron Cemetery	Oct 7 - 1923
20-UNDERTAKER.	**ADDRESS**
Isaac Lewis	1439 Eutaw Pl

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79694

CERTIFICATE OF DEATH.

90 D 79694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 McCulloh St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Palestine Hospital

2-FULL NAME

(a) RESIDENCE NO. 1422 McCulloh St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Turner

6 DATE OF BIRTH (month, day, and year): Nov 2 1870

7 AGE: Years 53 Months 7 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos N Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Priscilla Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Priscilla Cook 1422 McCulloh St.

15 Filed OCT 3 - 1923, 19 ROBERT H. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1923, to Oct 4th, 1923, that I last saw h alive on Oct 3rd, 1923, and that death occurred, on the date stated above, at 10 Pm, m.

The CAUSE OF DEATH* was as follows: Pulmonary Tbc of Heart (Acute)

(duration) Life yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wetzler, M. D.

, 19 (Address) 609 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlawn

DATE OF BURIAL: Oct 7 1923

20 UNDERTAKER: Samuel Hawley

ADDRESS: Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79695

CERTIFICATE OF DEATH.

D 79695

1-PLACE OF DEATH Maryland General Hospital. 12

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James Sullivan

(a) RESIDENCE NO. 419 E. Lafayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) Marine Engineer

(c) Name of employer Government U.S.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Matthew Sullivan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tipperary Ireland.

14 Informant Mary Frances Sullivan

(Address) 419 E. Lafayette Ave, Balt.

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1923, to Oct. 6, 1923,

that I last saw him alive on Oct. 6, 1923

and that death occurred, on the date stated above, at 1:55 P.m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis, Probably Malignant (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray & Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct. 9 1923

20 UNDERTAKER George F. Rutt — ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79696

CERTIFICATE OF DEATH.

129

D 79696

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Ridgewood ave ST., 15 WARD)

2-FULL NAME John F Ziegler

(a) RESIDENCE No. 2016 Ridgewood ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Annie Ziegler

6 DATE OF BIRTH (month, day, and year) May 17 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buschler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer George Plitt

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John F. Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Bertha Ziegler (Address) 2016 Ridgewood ave

15 Filed OCT 7 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 19 23

17 I HEREBY CERTIFY, that I attended deceased from July 15 1923 to Sept. 4 1923

that I last saw h[illegible] alive on Sept 4 1923

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis?

(Signed) Irvin Ebaugh M. D.

Oct 5 1923 (Address) 701 W. W. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Co. Emory Chapel Cemetery

DATE OF BURIAL Oct. 8 1923

20 UNDERTAKER Thos. F. Feeth

ADDRESS 1235 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79697.

CERTIFICATE OF DEATH.

73 D 79697.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 Whitelock ST. 19 WARD)

2-FULL NAME Myer Plaut

(a) RESIDENCE NO. 935 Whitelock ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Plaut

6 DATE OF BIRTH (month, day, and year): Jany 10 1852

7 AGE — Years: 71 — Months: 8 — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Abraham Plaut

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Detterie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Bessie Plaut 935 Whitelock St.

15 Filed OCT 8 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/6/1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1923, to Oct 6, 1923,

that I last saw h alive on Oct 6, 1923,

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

Senility

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Decubitus ulcer (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Grover C Ney M. D.

, 19 (Address) 2201 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Meb. Cem.

DATE OF BURIAL: 10/7/1923

20 UNDERTAKER: David Sondheim

ADDRESS: 108 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79698

D 79698

114

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4010 Eastern Ave ST., 26 WARD)

2-FULL NAME Elizabeth E. Klein

(a) RESIDENCE NO. 4010 Eastern ST., WARD 26
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): May 15 1920

7 AGE — Years: 3 Months: 4. Days: 20 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Andrew E Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Amelia Reimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Andrew Klein
(Address) 4010 Eastern Ave

15 Filed OCT 9 1923 ROBERT R. KRANTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1923 to Oct 4 1923, that I last saw her alive on Oct 4 1923, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

exhaustion following
enteritis, acute, data

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary): dietary indiscretion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

Oct 6 1923 (Address) 1014 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: John Leavitt — ADDRESS: [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79699

D 79699

CERTIFICATE OF DEATH.

16 X 44

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1031 Harlem Ave — St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Susan Loretta Ragen

(a) Residence No. Monrovia, Md. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rufus Ragen

6-DATE OF BIRTH (month, day and year) Jan. 5, 1855

7-AGE. 68 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Highland, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Jonathan Boyer

11-BIRTHPLACE OF FATHER (city or town) Highland, Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Katherine Blessing

13-BIRTHPLACE OF MOTHER (city or town) Highland, Md.
(State or Country),

14- (Informant) Miss Bessie D. Ragen

(Address) 1031 Harlem Ave.,

15-

Filed ..... 192.....

ROBERT P. KRAUTER,
Registrar.

OCT 9 1923

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 6 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15th 19 23 to Oct. 6, 19 23

that I last saw her alive on Oct. 6, 19 23

and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

abdominal carcinoma (most probable - carcinoma of liver)

.....(Duration).....yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) auricular fibrillation

.....(Duration).....yrs.....mos. 9 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) George F. Knapp M. D.

, 19 (Address) 1002 W. Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Md. DATE OF BURIAL, Oct 8th 19 23

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79700

105 D 79700

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Gay St. ST., 10 WARD)

2-FULL NAME Abraham Rosenblum

(a) RESIDENCE NO 808 N Gay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida (MELTZER) Rosenblum

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retail Dry Goods
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Alex. Rosenblum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freda Lipsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ida Rosenblum
(Address) 808 N. Gay St.

15 Filed OCT 4 - 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inqiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) several yrs. mos. ds.

(Signed) [signature], M. D.
(Coroner.)

10/6/23. 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lbur Mt Carmel	10/7 1923
20 UNDERTAKER	ADDRESS
L. Grinsfelder Bro	E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79701

CERTIFICATE OF DEATH.

9 D 79701

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D. Burns

(a) RESIDENCE NO 1118 W.Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred XXXXX 2 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) July 17/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John P. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lottie Orndorff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant John P. Burns
(Address) 1118 W. Lombard St.

15 Filed OCT 9 - 1923, 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6/23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pertussis (duration) yrs. mos. ds.

(Signed) J. H. Collins (Coroner.), M. D.

10/7/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Oct 8th 1923

20 UNDERTAKER J J Cowan

ADDRESS 901 Hopkins

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79702

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 41

D 79702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) St Agnes Hospital (St.) 70 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E Jones

(a) RESIDENCE No. 2170 Hollins St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~: Widowed

5a If ~~married~~, widowed, or divorced HUSBAND of (or) WIFE of: not known

6 DATE OF BIRTH (month, day, and year): May 6/1859

7 AGE: Years 64 | Months 5 | Days — | If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs Ada McCullough

(Address) 2170 Hollins St

15 Filed OCT 7 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923, to Oct 6, 1923, that I last saw h— alive on Oct 6, 1923, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia following Lacerated (L) infection (duration) yrs. 1 mos. 19 ds.

18 Where was disease contracted if not at place of death? municipal service

Did an operation precede death? Laud Date of Sept 17

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Harper, M. D.

, 19 (Address) St Agnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mosley Chapel Cem Rockville Md — DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Harry R Armacost 4204 — ADDRESS: Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 79703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79703

CERTIFICATE OF DEATH.

1925

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 26 E Charles ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME G. Edgar Hampshire

(Residence in Baltimore: No. 3732 Hickory Ave. St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. 26, 1896
(Month) (Day) (Year)

7-AGE, 27 yrs. — mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Co.

PARENTS.

10-NAME OF FATHER, Wm. E. Hampshire

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Sarah E. Price

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. E. Hampshire

(Address) 3720 Edmondson Ave.

15-

Filed OCT 9 - 1923, 191....

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries received from a fall

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. H. Morrison M. D.
(Coroner.)

Oct 6, 1923 (Address) 3692 Roslyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Oct 8, 1923

20-UNDERTAKER Horace G. Burgan — ADDRESS 3021 Falls Rd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 79704

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1908 Mosher St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Addison.

(a) RESIDENCE. No. 1908 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Wm W Addison

6 DATE OF BIRTH (month, day, and year) Sept 13, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry St. Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury N. C.

12 MAIDEN NAME OF MOTHER Elizabeth Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville Kentucky

14 Informant Wm W Addison
(Address) 1908 Mosher St

15 Filed OCT 7 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Oct 6, 1923, that I last saw h[illegible] alive on Oct 6, 1923, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Industrial nephritis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Analysis

(Signed) J. Thomas Fulton, M. D.

19 (Address) 1001 N Dulaney ave

OCT 7 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL OCT 9 1923

20 UNDERTAKER Geo W Little

ADDRESS 2[illegible] EDMONDSON AVE.

Spec.—1-10-21—M&T—1500 Blks. 79705

HEALTH DEPARTMENT—CITY OF BALTIMORE

1923 D 79705

CERTIFICATE OF DEATH.

D 79705

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Elmer Alt

(a) RESIDENCE NO. 15 N. Rose St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1923.

7 AGE — Years — Months 28 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Walter Alt.

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Hilda Eder

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant (Address) Record

15 Filed OCT 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1923 19 .. to Oct 6, 1923 19 .. that I last saw him alive on Oct 6, 1923 19 .. and that death occurred, on the date stated above, at 1:25 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) .. yrs. .. mos. 5 .. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ..

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Count

(Signed) H. N. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 10/7/1923

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

79706 D 79706

HEALTH DEPARTMENT—CITY OF BALTIMORE D 79706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 188-003

CITY OF BALTIMORE (No. St. Agnes Hospital St.: 25 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Octavia O Durban

(Residence in Baltimore: No. Springs From Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. January 18, 1903 (Month) (Day) (Year)

7-AGE. 20 yrs. 8 mos. 18 ds. — If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Springs Grove

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Charles Durban

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Enova Smith

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna M. Hewett
(Address) Woodbine, Md.

15- Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

OCT 7 1923 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6- (Month) (Day), 19.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
and Accident

(Duration) .... yrs. .... mos. 5 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) .... mos. .... ds.

(Signed) Geo Clinton Wedes M. D.
(Coroner)
Oct 6 1923 (Address) 143 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Brandenburg Cemetery — DATE OF BURIAL. Oct 9th 1923

20-UNDERTAKER Carroll & Moh ADDRESS 3000 E. Baltimore St

John A. Norman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79707.

CERTIFICATE OF DEATH.

16 D 79707

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 129 N Fort ave St. 23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Dennery

(a) RESIDENCE NO. 129 N Fort ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Dennery

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 76 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Keep

(c) Name of employer: 000

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John P Dennery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Thos. W. Dennery 129 N Fort ave

15 Filed OCT 8 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Oct 6, 1923.

That I last saw h alive on Oct 6, 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(duration) 2 yrs. mos 1 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ..... yrs. mos. 2 Mos.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Campbell, M. D.

Oct 6, 1923 (Address) 644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Oct 8, 1923

20 UNDERTAKER: Margaret L. Flynn — ADDRESS: 142 Light St

Spec.—1-10-21—M&T—1500 Bks.

D 79708 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79708

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 70 WARD)

2-FULL NAME William Dougherty Jr

(a) RESIDENCE NO. 4130 Hallas Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Nov. 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): ~~None~~

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant: Wm Dougherty

(Address) 4130 Hallas Ave

15 Filed ..... , 19 ..... Registrar

OCT 8 1923 ROBERT A. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-6 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-13, 1923, to 10-6, 1923, that I last saw him alive on 10-6, 1923, and that death occurred, on the date stated above, at 5-12 P. m.

The CAUSE OF DEATH* was as follows:

Empyema.

(duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 10-6-23

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Margaret A. Flynn

ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79709

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓ D 79709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 McMechen St. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia Poulson.

(a) RESIDENCE No. 206 McMechen ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1841

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ------- no

(c) Name of employer -------

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Alexander W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Elizabeth J. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Elizabeth Poulson.
(Address) 206 McMechen St. City

15 Filed OCT 8 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 4. 9 a.m., 1923, to Oct 5 6 p.m., 1923, that I last saw her alive on Oct 5, 1923, and that death occurred, on the date stated above, at 6-15 P m.

The CAUSE OF DEATH* was as follows: Left Side
Hemiplegia (Cerebral Hemorrhage
with paralysis right side
(duration) .. yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Coma
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Dr. Robert W. Mifflin, M. D.

(Address) No 1016 Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	10/8/23
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79710

CERTIFICATE OF DEATH.

9 D 79710

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 402 N. Robinson St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Maida M. Zimmerman

(a) Residence No. 402 N. Robinson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry

6-DATE OF BIRTH (month, day and year) Oct 29, 1922

7-AGE, 0 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... No

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry Zimmerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Catherine Loguen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Harry Zimmerman

(Address) 402 N. Robinson St.

15-

Filed....., 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 6th 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 29th, 19 23 to Oct 6th, 19 23

that I last saw her alive on Oct 1st, 19 23

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. McCarthy, M. D.

, 1923 (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Bonnie Brae — DATE OF BURIAL, Oct. 8 1923

20-UNDERTAKER, E. W. Franklin — ADDRESS 724 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79711

CERTIFICATE OF DEATH.

23 D 79711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 685 Vine ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME alice chase

(Residence in Baltimore: No. 685 Vine st St.; 21 yrs., 4 mos. 9 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fe

4-COLOR OR RACE, Col

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, May 27, 1902
(Month) (Day) (Year)

7-AGE, 21 yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... D°

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Chase

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lula Jones.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Chase

(Address) 685 Vine St

15-

Filed ....., 191...

ROBERT M. KRAUTER, Registrar.

OCT 8 - 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1923, to Oct 6 1923, that I saw h e alive on Oct 5 1923, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. N. Hing M. D.

Oct 6, 1923 (Address) 65-1 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 8, 1923

20-UNDERTAKER Daniel Carroll

ADDRESS 916 Druid Hill Ave

Remarks Lethargical. Nov 15 06

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79712

CERTIFICATE OF DEATH.

69

D 79712

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 W. Conway ST.: W WARD)

2-FULL NAME Benjamin H Crawford

(a) RESIDENCE. NO. 624 W. Conway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriett R. Crawford

6 DATE OF BIRTH (month, day, and year): Sept 5th 1858

7 AGE — Years: 35 — Months: 1 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer): 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George W. Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Spurrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Harriett R. Crawford (Address): 624 W. Conway st

15 Filed OCT 8 - 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922, to Oct. 5, 1923, that I last saw ~~he~~ alive on Oct. 4, 1923, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Sclerosis Insipidus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Elkridge Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E Travers M. D.

10/6, 1923 (Address) St. Denis Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Oct 7th 1923

20 UNDERTAKER: E. Eichelman & Son

ADDRESS: 1057 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79713

D 79713

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chestnut & Gunter Ave. St.; 7 WARD) Gardenville

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gunther (Gunter)

(Residence in Baltimore: No. Chestnut & Gunter Ave. Gardenville St.; 77 yrs. 10 mos. 10 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. 26, 1845 (Month) (Day) (Year)

7-AGE, 77 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): Truck farm

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Truman Gunther

11-BIRTHPLACE OF FATHER (State or Country) Balto. City

12-MAIDEN NAME OF MOTHER Mary Schoue

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gunter

(Address) Reisterstown R. F. D. Md

15-

Filed OCT 8 1923 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from August 10 1923, to Oct 6 1923, that I saw h alive on Oct 5 1923, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Cancer (Stomach)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) C. D. Corse M. D.

Oct 6, 1923 (Address) Gardenville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL. Oct. 8, 1923

20-UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fullerton Md.

Spec.—1-10-21—M&T—1500 Bks.

D 79714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79714

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Curtain

(a) RESIDENCE NO. 2009 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or (Divorced) (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Curtain

6 DATE OF BIRTH (month, day, and year) Feb 7-1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago

PARENTS

10 NAME OF FATHER Martin Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Slattery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward M. Curtain

(Address) 2009 E Biddle St

15 Filed OCT 8 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1923, to Oct 6, 1923, that I last saw her alive on Oct 6, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Incompetency

Intestinal Obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia & Gall Bladder & Stomach Duodenum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2009 E. Biddle St.

Did an operation precede death? Yes Date of 10/3/23

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Geo. B. Sybert M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL Oct 9 1923

20 UNDERTAKER William Cook

ADDRESS 502 E Pratt

Spec.—1-10-21—M&T—1500 Bks.

D 79715 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 79715

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Men's Home St., 19 WARD)

2-FULL NAME Delaware C Thomas

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23 1824

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	102	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): OTD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: Josiah Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Virginia

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Virginia

14 Informant: Mr H W Tillman

(Address) 1400 Lexington Baltimore

15 Filed OCT 8 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 19 23, to Oct 6, 19 23,

that I last saw h alive on Oct 6, 19 23

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood M. D.

Oct 8 19 23 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: George J Smith — ADDRESS 1512 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79716

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 44 D 79716

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Boltz Gen Hosp St., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno F Kelly

(a) RESIDENCE NO. Laurel Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 27 - 1874

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer [redacted]

9 BIRTHPLACE (city or town) (State or country) [redacted]

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital record, (Address)

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Oct 6, 1923, that I last saw h[illegible] alive on Oct 6, 1923 and that death occurred, on the date stated above, at 7:15 AM.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Test meal +

(Signed) from H. C. Wilcox, M. D.

Oct 8 1923 (Address) South Boltz Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Seattle - Washington — DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: agent Ry Express — ADDRESS: John F Denny — 715 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D 79717. 74-001 ✓ D 79717.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 W. Franklin ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia E. Bell.

(a) RESIDENCE No. 1803 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David E. Bell.

6 DATE OF BIRTH (month, day, and year): Aug. 12. 1854

7 AGE — Years: 69 — Months: 1 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Wholey.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know.

12 MAIDEN NAME OF MOTHER: Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know.

14 Informant: David E. Bell.

(Address) 1803 W. Franklin St

15 Filed OCT 8 - 1923 ROBERT R. KRAUSER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/24, 1923, to Oct. 6, 1923, that I last saw her alive on Oct. 6, 1923, and that death occurred, on the date stated above, at 12.30 Noon m.

The CAUSE OF DEATH* was as follows:

1. Cerebral Apoplexy

(duration) 0 yrs. 0 mos 12 ds.

CONTRIBUTORY (Secondary) Hypostasis of

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. C. Hamer, M. D.

, 19 (Address) 700 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Oct. 9. 1923

20 UNDERTAKER: Chas. J. John H. Tenfel & Son ADDRESS 84 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79713

CERTIFICATE OF DEATH.

90 D 79713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3405 Gwynn Oak Ave. (WARD) 28

2-FULL NAME Irving Hellen

(a) RESIDENCE NO. 3405 Gwynn Oak Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the~~ word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances E. Gaskins Hellen

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE — Years: 55 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Sho

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hellen

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Lillie Bimyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Frances E. G. Hellen

(Address) 3405 Gwynn Oak Ave

15 Filed OCT 8 - 1923 19 ROBERT B. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to Oct. 5, 1923, that I last saw him alive on Oct 5, 1923, and that death occurred, on the date ~~stated above~~ Oct 6, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis, Streptococcus viridans

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) disease: Chronic valvular heart disease (duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood cultures

(Signed) Adam C. Sutton, M. D.

10/8, 1923 (Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 79719

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3534 Benson St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Inary L Wilt

(a) RESIDENCE. NO. 3534 Benson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 6 1923

7 AGE: Years — Months 3 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Balto Md
(State or country) Gilbert L Wilt

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Ind
(State or country)

12 MAIDEN NAME OF MOTHER Mary Tinsburg

13 BIRTHPLACE OF MOTHER (city or town) Ind
(State or country)

14 Informant Gilbert Wilt
(Address) 3534 Benson St

15 Filed OCT 8 1923, 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1923

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1923, to Octobr 7th, 1923, that I last saw h.a alive on Oct 7, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) ~~yrs.~~ 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Indigestion
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Oct 8 23 (Address) 8650 W. 36th Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alberton Howard Co. DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: CHENOWETH & SON ADDRESS: 3617 CHESTNUT AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79720

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

D 79720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louis Eckenstein

(a) Residence No. 2907 Huntington Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1840

7-AGE.	If LESS than 1 day,
80 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ?

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Pa.
(State or Country),

PARENTS.

10-NAME OF FATHER, Ernest Eckenstein

11-BIRTHPLACE OF FATHER (city or town) Pa.
(State or Country),

12-MAIDEN NAME OF MOTHER, Caroline Krause

13-BIRTHPLACE OF MOTHER (city or town) Pa.
(State or Country),

14- (Informant) Hospital Records

(Address)

15- Filed OCT 8 1923 ROBERT R. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/6/23.

17- I HEREBY CERTIFY, That I attended deceased from 9/27/27, 19.. to 10/6/23 19..

that I last saw h~~im~~ alive on 10/6/23 19..

and that death occurred, on the date stated above, at 12.05 m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism 15 min.

(Duration) ? mos. ds.

18-Where was disease contracted if not at place of death? Yes Huntington

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathol & Clinical

(Signed) K. W. Dooley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Phila Pa	Oct 9, 19 23

20-UNDERTAKER. OHENOWETH & SON ADDRESS 2012 CHESTNUT ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79721

CERTIFICATE OF DEATH.

185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Frankstein Sq Hospital ST., WARD)

2-FULL NAME Henry R Guest.

(a) RESIDENCE NO. 1244 Hoyard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 21/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER Francis Guest

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Mulmore

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant William F Guest
(Address) 2011 Wilkens Ave

15 Filed OCT 8 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 - 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured of Skull
Accident

(Duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades, M. D.
(Coroner)
Oct 1 1923 (Address) 1436 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 9 1923

20 UNDERTAKER Harry R Amacost ADDRESS 4204 Ridgewood Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Stevens

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79722

CERTIFICATE OF DEATH.

X 91-002 D 79722

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4302 Ridgewood Ave ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Abraham

(a) RESIDENCE No. 4302 Ridgewood Ave ST., ... WARD Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~: Martha Clark Stevens

6 DATE OF BIRTH (month, day, and year): June 10/1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Chauncey Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Eliza Jillett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Elizabeth Johnston
(Address): 4302 Ridgewood Ave.

15 Filed: OCT 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1923, to Oct. 8, 1923, that I last saw him alive on Oct. 7, 1923, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) J. M. Lamperin, M. D.

(Address) 826 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Oct 10 1923

20 UNDERTAKER: Harry M Abraham X 4304

ADDRESS: Ridgewood Ave

Spec.—1-10-21—M&T—1500 Bks.

D 79723

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

D 79723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Raborg ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Cassell

(a) RESIDENCE NO. 828 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Cassell

6 DATE OF BIRTH (month, day, and year): March 5 - 850

7 AGE — Years: 73 — Months: 7 — Days: 0 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Sleet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Harriet Tillman

(Address): 828 Raborg

15 Filed OCT 8 1923, 19 — Registrar

ROBERT M. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Oct 5, 1923, that I last saw her alive on Oct 4, 1923, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William E Burton, M. D.

10-5, 1923 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Auburn — DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: Sam'l M. Chase & Son — ADDRESS: 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 79724 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75 D 79724

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 524 W. Barre ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lewis

(a) RESIDENCE. No. 524 W. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Oct 8, 1866

7 AGE: 57 Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ga

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Rosetta Lewis (Address): 524 Barre St

15 Filed . 19 .. Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to Oct 4, 1923

that I last saw h[illegible] alive on Oct 4 1923

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? — What test confirmed diagnosis? Physician's Symptoms

(Signed) C. H. Hooper, M. D.

1923 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Lawn Cemetery — DATE OF BURIAL: Oct 7 1923

20 UNDERTAKER: Bros Gerth Hooper — ADDRESS: 406 W. Conway St

Be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79725

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 79725

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH The Kinnaird

CITY OF BALTIMORE: (No. 102 Russell ST. 25 WARD)

2-FULL NAME Annie Vaughan

(a) RESIDENCE. No. 102 Russell ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): Oct 7, 1895

7 AGE: Years 28 Months 9+7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 537

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Danville Ind

PARENTS

10 NAME OF FATHER: Richard Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mitchell mills Ind

12 MAIDEN NAME OF MOTHER: Annie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind

14 Informant: Robt W Vaughan

(Address): 102 Russell st

15 Filed ..... 19..... Registrar

OCT 8 1923 ROBERT R. CRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1923, to Oct 5 1923

that I last saw her alive on Oct 4 1923

and that death occurred, on the date stated above, at 10,30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

sow

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) C. O. Thomas M. D.

(Address) 712 S Mont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER: Jno Geo H Hooper — ADDRESS: 406 W. Conway St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

D 79723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79723

161-009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) St Agnes Hospital ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Adams

(a) RESIDENCE NO. 5206 St Chas Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 11 hrs. or 50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Amory Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Mary Ferrario

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Phillip Adams (Address) 5206 St Charles Ave

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 - 1923 to Oct 5 - 1923, that I last saw her alive on Oct 5 - 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: Martin Gachet Son — ADDRESS: 827 N North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79727. 129 D 79727.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2052 E Hoffman St. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Baker.

(a) RESIDENCE NO. 2052 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T Baker.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Sarah M Dignard.

13 BIRTHPLACE OF MOTHER (city or town) Paris. (State or country)

14 Informant Miss Edva Baker. 2052 Hoffman (Address)

15 Filed OCT 8 1923 ROBERT R. KRAUT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27 1923, to October 5 1923, that I last saw her alive on October 5 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis, hypertension and mitral insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown — No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Clem Cronenberg M. D.

10/7 1923 (Address) 207 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 9 19

20 UNDERTAKER John Ullrich — ADDRESS 2009 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.P.S.—400 Bks.

Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79723

CERTIFICATE OF DEATH.

34

D 79723

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James J Mount.

(a) Residence No. 1230 E. Eager St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single~~ Married ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~1878~~ Mary E. Mount

6-DATE OF BIRTH (month, day and year) 1878

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. SHS

(b) General nature of industry, business, or establishment in which employed (or employer). Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Hospital Records

(Address).....

15- Filed OCT 8 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/6/23

17- I HEREBY CERTIFY, That I attended deceased from 10/5/23 19.... to 10/6/23 19....

that I last saw h— alive on 10/6/23 19....

and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Syphilis.

?

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Stallman M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. Oct 9 1923

20-UNDERTAKER. George J. Reuth

ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 7.9723

CERTIFICATE OF DEATH.

101-601 ✓ D 7.9723

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 W. Lafayette Ave. ST., 16 WARD)

2-FULL NAME Bertha Lee Boice

(a) RESIDENCE No. 2723 W. Lafayette Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 4 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Robert C. Boice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Boice

(Address) 2723 W. Lafayette Ave.

15 Filed , 19 Registrar

OCT 8 - 1923 ROBERT A. KHAUN Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Oct. 7 - , 1923.

that I last saw her alive on Oct. 7 - , 1923,

and that death occurred, on the date stated above, at 7-45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) - yrs. - mos 4 ds.

CONTRIBUTORY (Secondary) Pleurisy & bronchitis

(duration) - yrs. - mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Phys. Dgn.

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Phila. Pa.

DATE OF BURIAL 10/9 1923

20 UNDERTAKER J. Fran McCully

ADDRESS 130 E. Fort

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79730

114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1011 Wilcox St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Nora J. Cumberland

(a) Residence No..... 1011 Wilcox St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of No

6-DATE OF BIRTH (month, day and year) Feb 3- 1919

7-AGE, 4 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Cumberland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md Balto

12-MAIDEN NAME OF MOTHER, Nora Ormond

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Father George Cumberland

(Address) 1011 Wilcox St.

15-

Filed..... 192.. ROBERT R. KRAUTER, D.

Registrar.

OCT 8 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 8-1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 7th, 1923, that I last saw her alive on Oct 7, 1923, and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Sore toxemia Unknown
vomit with acute Gastro-
Enteritis

(Duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary) Not Known

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of XX

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) D. F. Duker M. D.

Oct 8. 1923 (Address) 928 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem. DATE OF BURIAL, Oct 10, 1923

20-UNDERTAKER. C. H. Conklin ADDRESS 924 E Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79731

CERTIFICATE OF DEATH.

D 79731

REGISTERED NO. 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Ag's Hospital ST., 25 WARD)

2-FULL NAME Agnes Fisher

(a) RESIDENCE NO. Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 3 0 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Switzerland
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant M. A. T. Sang
(Address) Catonsville Md

15 Filed OCT 8 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH was as follows:
Auto Acc.
Multiple Fractures
(duration) — yrs. — mos. 1 ds.
CONTRIBUTORY Shock
(Secondary)
(duration) — yrs. — mos. 1 ds.

(Signed) Geo Walter Wades, M. D.
(Coroner)
Oct 5, 1923 (Address) 143 N Gay

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct. 10 1923

20 UNDERTAKER Penney Funeral Home — ADDRESS 1301 Eager

INSTRUCTIONS—PRINT WITH FOUNTAIN PEN INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79732

CERTIFICATE OF DEATH.

113 D 79732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Furley near Fairview Ave ST. Gardenville. WARD 76)

2-FULL NAME Philip J. Holthaus

(a) RESIDENCE NO. Furley near Fairview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 26 1923

7 AGE — Years: — Months: 1 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philip J. Holthaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Minnie Hildp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. Philip J. Holthaus (Address): Furley Ave near Fairview Ave

15 Filed: OCT 8 - 1923 Registrar: ROBERT R. KRAMER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 — 1923 to Oct 7 1923

that I last saw him alive on Oct 7 1923

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? pending

(Signed) Fred Bennett R M. D.

Oct 8, 1923 (Address) 800 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Henry Horch Son — ADDRESS: 801 Eager St

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79733

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

D 79733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martin Kumpf Jr.

(a) Residence No. Preston & Bailey Sts. St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, Widowed, ~~or Divorced~~. (Write the word.) Widower

5a-If ~~married~~ widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Gingunda Wetzell.

6-DATE OF BIRTH (month, day and year) Jan. 1844.

7-AGE. 79 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Germany
(State or Country).

PARENTS.

10-NAME OF FATHER. John Kumpf.

11-BIRTHPLACE OF FATHER (city or town). Germany
(State or Country)

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town). Unknown
(State or Country).

14-(Informant) Sister Florence

(Address) Preston & Bailey

15-Filed OCT 8 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 7 1923

17- I HEREBY CERTIFY, That I attended deceased from 10/3, 1923, to 10/7, 1923

that I last saw h alive on 19

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Wellman Wood M. D.

10/8 1923 (Address) 614 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Oct. 10, 1923
20-UNDERTAKER.	ADDRESS
Henry Strock Son	201 Eager St.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79734

CERTIFICATE OF DEATH.

90 D 79734

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1648 Millinan ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John C. Kettering

(a) RESIDENCE. NO. 1648 Millinan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Catherine Kettering

6 DATE OF BIRTH (month, day, and year) Nov 16th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	83	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Peter Kettering

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Emma Kettering
(Address) 1648 Millinan St

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1923, to Oct 6, 1923, that I last saw h[illegible] alive on Oct 6, 1923, and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis and
Pat dis heart - Mitral

Some Years - undefined (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Oct 7 1923 (Address) 2246 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 10th 1923
20 UNDERTAKER	ADDRESS
Geo Schilling & Sons	112 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79735 CERTIFICATE OF DEATH ✓ X73 D 79735

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard T Summers

(a) RESIDENCE NO. Ithaca N. Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29th 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer) 24

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas W Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentuckey

12 MAIDEN NAME OF MOTHER Mary Fairchild

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indianna

14 Informant Thomas W Summers

(Address) Ithaca N. Y.

15 Filed OCT 8 - 1923, 19 ROBERT R. KRAUTEN, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1923, to Oct 7, 1923, that I last saw him alive on Oct 7, 1923, and that death occurred, on the date stated above, at 5p. m.

The CAUSE OF DEATH* was as follows:

Encephalitis, Acute

(duration) yrs mos 13 dys

CONTRIBUTORY (Secondary) Bulbar Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Caycteno Paulucci, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ithaca N. Y.	Oct. 8th 1923
20 UNDERTAKER	ADDRESS
H. E. Hughes	434 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79736

D 79736

CERTIFICATE OF DEATH.

24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Decker.

(a) RESIDENCE NO. 2863 Philadelphia ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Decker

6 DATE OF BIRTH (month, day, and year) Nov 3 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) md

PARENTS

10 NAME OF FATHER John Decker

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Florence Gross

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant Hospital Record. (Address)

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1923, to Oct 7, 1923, that I last saw living on Oct 7, 1923, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Meningitis, epidemic

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Spinal fluid.

(Signed) Billingsworth, M. D.

Oct 8/23 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct 8 1923

20 UNDERTAKER Mrs E. Miller — ADDRESS 2537 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 79737

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Franklin ST., 11 WARD)

2-FULL NAME Hortense C. Dorsey

(a) RESIDENCE NO. 16 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Walter C. Dorsey

6 DATE OF BIRTH (month, day, and year): Apr. 4 1875

7 AGE: Years 48 | Months 6 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm A Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Viers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Dr. Walter C. Dorsey

(Address): 16 W Franklin St

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 7, 1923,

that I last saw her alive on Oct 7, 1923,

and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Phys Exam.

(Signed) Geo M Lear, M. D.

Oct 7, 1923 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Wm Tickner & Sons — ADDRESS: North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 7.9733 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 D 7.9733

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 Highfield ST. Fulford WARD)

2-FULL NAME Mrs Annie P Deverell.

(a) RESIDENCE. NO. 1 Highfield ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

England

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances D Deverell

6 DATE OF BIRTH (month, day, and year): Aug. 15, 1847

7 AGE: Years 76 Months 1 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): London England

PARENTS

10 NAME OF FATHER: James Allerton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eng

12 MAIDEN NAME OF MOTHER: Sophia Aikam

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eng

14 Informant (Address): Frank A. Deverell Highfield & Fulford

15 Filed OCT 8 1923 19 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1923, to Oct 6, 1923, that I last saw h[illegible] alive on Oct 6, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Senility + Intestinal carcinoma - Chronic Diarrhoea

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary): General Prostration with [illegible] (duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Wesley Cole, M. D.

(Address) 2707 Gwynn.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 8 1923

20 UNDERTAKER: Wm J Leickner Sons — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79739

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 N. Milton Av ST., 1 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Doehring

(a) RESIDENCE No. 638 N. Milton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 8/1906

7 AGE — Years: 17 — Months: — — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wood

(b) General nature of industry, business, or establishment in which employed (or employer): Finisher

(c) Name of employer

914

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Gustav F. Doehring

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Gillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Doehring

(Address): 638 N. Milton Av

15 Filed , 19 Registrar

OCT 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Oct 5, 1923, that I last saw h[illegible] alive on Oct 5, 1923, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lewis, M. D.

10/6, 1923 (Address) 413 Worthington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 10/8 1923

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79740

CERTIFICATE OF DEATH.

46 D 79740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 99 W. Lanvale ST., 12 WARD)

2-FULL NAME Katherine Sisselberger

(a) RESIDENCE NO. 99 W. Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Sisselberger

6 DATE OF BIRTH (month, day, and year) Sept 28th, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	----	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose McWilliams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George Sisselberger

(Address) 99 W. Lanvale St

15 OCT 8 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1923, to Oct 6, 1923, that I last saw her alive on Oct 6, 1923, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Abdomen

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. D. Gelbert M. D.

10-7, 1923 (Address) 211 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct 10 1923

20 UNDERTAKER J. Pitzrath & E

ADDRESS Mt Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

D 79741

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 79741

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Arlington Ave. 18 WARD)

2-FULL NAME Ethel Corben

(a) RESIDENCE NO. 213 N. Arlington Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Oct 6 1922

7 AGE Years 1 Months Days 2 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Joseph Corbin

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Edna Topkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Edna Corbin

(Address) 213 N. Carlington Ave

15 Filed OCT 8 - 1923 ROBERT A. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Oct 4, 1923, that I last saw h[illegible] alive on Oct , 19 , and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Howell, M. D.

10/8/1923 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Oct 8 1923

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1732 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

Fanny Klein

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79742

CERTIFICATE OF DEATH.

49 D 79742

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fanny Klein

(a) RESIDENCE NO. 2228 Madeira Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Meyer Kline

6 DATE OF BIRTH (month, day, and year): September

7 AGE — Years: 72 — Months — Days — If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 Eutaw St

15 Filed OCT 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1923

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to October 7, 1923,

that I last saw h alive on October 7, 1923,

and that death occurred, on the date stated above, at 1-10 P m.

The CAUSE OF DEATH* was as follows:

Osteo-Sarcoma of right Femur

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) General Asthenia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidor J. Jay, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehram Rosedale — DATE OF BURIAL: 10/8 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D 79743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 79743

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Ethel Frohlich

(a) RESIDENCE NO. 6 E. Columbus ST., WARD Montgomery, Ala.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fanny Frohlich

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Heinrich Frohlich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria.

12 MAIDEN NAME OF MOTHER: Rachel Englander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant ..... JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed OCT 8 1923, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 19 23, to Oct 8, 19 23

that I last saw him alive on Oct 8, 19 23

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension & arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) P. R. Hannon, M. D.

Oct 8, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Montgomery Ala

DATE OF BURIAL: 10/8 1923

20 UNDERTAKER: Jack Levins 1439

ADDRESS: Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79744

CERTIFICATE OF DEATH.

90 D 79744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Wyanoke ave. St.) 9 (WARD)

2-FULL NAME Edwin D. Foley

(a) RESIDENCE NO. 620 Wyanoke ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 22-1901

7 AGE — Years: 22 — Months: 1 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Western Union Telegraph

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer 086

9 BIRTHPLACE (City or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John P. Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Welkemeier Deetzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John P. Foley

(Address): 620 Wyanoke Ave

15 Filed OCT 8 1923 Registrar

ROBERT A. KRAUTER, Assistant Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-6 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-1, 1923 to 10-6, 1923.

that I last saw h(M) alive on 10-4 1923

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. D. Foley, M. D.

19 (Address) 2959 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: 10/9/23

UNDERTAKER: H. C. Wedefeld — ADDRESS: 414 Gilmor St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history

Died April 3 1915

Spec.—1-10-21—M&T—1500 Bks.

D 79745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79745

11-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1522 Mt. Royal Ave. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Garrett

(a) RESIDENCE NO. 1522 Mt. Royal Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara E. Rosenberger

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer Zell Motor Car Co.

9 BIRTHPLACE (city or town) (State or country) Deer Park Garrett Co., Md.

PARENTS

10 NAME OF FATHER Michael Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Goff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Richard G. Garrett 1522 Mt. Royal Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 5, 1923,

that I last saw h[illegible] alive on Oct. 5, 1923,

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Laryngitis Acute Bronchitis (Septal)

about a week, ill bed 4 days.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis Pneumonia Myocardial Insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank R. Smith, M. D.

Oct. 6, 1923 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 10/9 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT8-1923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79746

D 79746

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Park Ave St.; 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph M. Burton

(Residence in Baltimore: No. 1805 Park Ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March 22, 1868 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 6 mos. 15 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Auditor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Robert Burton

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Jefferson

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Burton

(Address) 1805 Park Avenue

15-

Filed ..... 191.....

Registrar.

OCT 8 - 1923

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1922, to March 1923, that I saw him alive on June 20 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Hypertrophy & Dilation of Heart

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy & Dilation

(Duration) yrs. mos. ds.

(Signed) Wm M Burton M. D.

Oct 7, 1923 (Address) 1805 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 5 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Oct. 9, 1923

20-UNDERTAKER B. LeRoy Steffler ADDRESS 125 E North Ave

Cor.—1-12-23—M&T—100 Bks.

(Stankunas)

D 79747.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79747.

X 169

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jones Falls Expressway ST., 3 WARD)

2-FULL NAME John Stankunas

(a) RESIDENCE NO. Brooklyn N.Y. ST., ... WARD Brooklyn. N.Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? — Single ?

6 DATE OF BIRTH (month, day, and year) About 1895

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer Probably none

9 BIRTHPLACE (city or town) unknown
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) unknown

14 Informant Geo. Kaibus - 142-N-10-St
(Address) Brooklyn N.Y.

15 Filed ..... 192 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

CT 8 - 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5. 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Drowning

(Duration) ..... yrs ..... mos 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs ..... mos 1 ds.

(Signed) Geo Clinton Blades M. D.
(Coroner)

Oct 8, 1923 (Address) 1436 N Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence Brooklyn N.Y.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn. N.Y.

DATE OF BURIAL Oct 8 1923

20 UNDERTAKER [illegible] COMPANY
(William F. Wooden, Successor)

ADDRESS 108 W. North Ave

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79743

CERTIFICATE OF DEATH.

31

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1172 W Hamburg ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Smoot

(a) RESIDENCE NO. 1172 W Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Cecelia Dorsey Smoot

6 DATE OF BIRTH (month, day, and year) Aug 5 " 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rivet Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett Hayward Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thom L Smoot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine E Peter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Catherine Schellenberg (Address) 1137 W Fort St

15 Filed OCT 8 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1923, to 10/6, 1923,

that I last saw h alive on 10/6/23, 19

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB,

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Milford D Cain M. D.

, 19 (Address) 1229 Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesley Cemetery

DATE OF BURIAL Oct 9th 1923

20 UNDERTAKER John J Cowan & Son

ADDRESS Forest Hall Md

J. Set JJ Cowan

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79749 X 188-002 D 79749

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

2-FULL NAME Melvin A. Bozman

(a) RESIDENCE No. 2040 E.Flayette St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Oct. 13/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Street Railway
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md.

PARENTS

10 NAME OF FATHER Alonzo Bozman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nora Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alonzo Bozman
(Address) Champ P.O. Md.

15 Filed OCT 8 1923, 192 Robert F. Harrison, Registrar
Burial Permit clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- rt. Leg crushed in St. car collision.
ZInquest to be held Oct 9/23

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Wallis, M. D.
(Coroner.)
10/8/23, 192 (Address) 508 E.North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Princess Anne Somerset Co. Md

DATE OF BURIAL 10/8 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Orash)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79750

90

D 79750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S Rose ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Orash

(a) RESIDENCE No. 802 S Rose ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widdow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widdow

6 DATE OF BIRTH (month, day, and year): 1861 - July 14

7 AGE: Years 62 Months 2 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Orash

(Address): Dillon St

15 Filed ..., 19 ... Registrar

OCT 8 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to Oct 6, 1923

that I last saw her alive on Oct 5, 1923

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

10/7. 1923 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Stephen J. Trachtenberg

ADDRESS: 1008 S Kenwood Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79751

CERTIFICATE OF DEATH.

31

D 79751

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 Asbury Ave. St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J. Wisbeck

(Residence in Baltimore: No. 9 Asbury Ave St.; 55 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 27, 1868

7-AGE, 55 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Peter J. Wisbeck

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Barbara Sauer

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond N. Wisbeck

(Address) No. 9 Asbury Ave

15-

Filed....., 191... Robert F. Harrison, Registrar.

T8-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923, to Oct 7 1923, that I saw h[illegible] alive on Oct 6 1923, and that death occurred, on the date stated above, at 7.20 m.

The CAUSE OF DEATH* was as follows:

Pleurisy, Fluid about Right Lung

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart Complication

(Duration) 0 yrs. ....mos. ....ds.

(Signed) Alwood Corse M. D.

....., 191... (Address) Jacksonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct. 10, 1923

20-UNDERTAKER Stephen J. MacKowski ADDRESS 1000 S. Kenwood

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH CARBON INK—THIS IS A PERMANENT RECORD

Remarks Probably Tuberculosis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Cor.—1-12-23—M&T—100 Bks.

D 79752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79752

112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 S. Gilmor ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Smith

(a) RESIDENCE NO. 2145 S Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Addie M. Smith

6 DATE OF BIRTH (month, day, and year) May 16, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Britt Haywood Co.

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Ferdinand Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Addie M. Smith
(Address) 2145 S. Gilmor St

15 Filed OCT 8 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Intoxication
Effects of Diet
(duration) yrs. mos. days.
CONTRIBUTORY Dil. Stomach
(Secondary)
(duration) yrs. mos. 1 ds.

(Signed) Geo. Luther Blades, M. D.
(Coroner)
Oct 9 1923 (Address) 1432 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westron Cemetery — DATE OF BURIAL Oct 9 23

20 UNDERTAKER Harry F. Witzke — ADDRESS 1531 W. Lombard St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79753

D 79753

160

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 663 Gutman Ave ST., 9 WARD)

2-FULL NAME Nora A Vandergrift

(a) RESIDENCE NO 66e Gutman Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 11/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Vandergrift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maud Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Wm. Gosnell
(Address) 663 Gutman Ave

15 Filed ....., 192 ..... Registrar

Robert F. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mal-nutrition

(Marasmus-probably improper feeding)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wallis, M. D.
(Coroner)

10/8/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Mal Cal? DATE OF BURIAL 192 3

20 UNDERTAKER Wm Carter ADDRESS 502 E N Ave

...ould be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...E OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... ...TION is very important. See instructions on back of certificate.

...8 - 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79754

CERTIFICATE OF DEATH.

129 D 79754

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1942 E. Lombard ST. 12 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Jung

(a) RESIDENCE. NO. 1942 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winifred Jung

6 DATE OF BIRTH (month, day, and year) — 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) O. K. Beverage

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Jung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin Dippel
(Address) 37 S. Amer St

15 Filed .19 Registrar

8-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1923, to Oct, 19, that I last saw him alive on Oct 4, 1923, and that death occurred, on the date stated above, at 6.50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
uremia & coma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Wound

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. R. Gary, M. D.

10/6 1923 (Address) 1727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct 9 1923

20 UNDERTAKER Martin Dippel — ADDRESS 37 S. Amer St

(Burial Permit Clerk)

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79755

CERTIFICATE OF DEATH.

188-003

D 79755

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J. Mallon.

(a) RESIDENCE No 410 N. Carrollton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---mos.--- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Mallon.

6 DATE OF BIRTH (month, day, and year) November 1, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Furniture salesman.
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Mallon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Holland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary Mallon. (wife)
(Address) 410 N. Carrollton Ave.

15 Filed OCT 9 - 1923, 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & (Inquest, autopsy or inquiry.) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General sepsis, due to a compound comminuted fracture of the fibula. thrown from an automobile. Accidental death. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Oct 8, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Annapolis Blvd. Linthicum Heights.

Former or usual residence September, 13, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct 9 1923

20 UNDERTAKER H. C. Brauning & Son Schroeder — ADDRESS 517

d be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stoc- 12-23-21- E.B.F.S.- 400 Bks.

D 79756 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79756

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Dishes ... St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Emmell

(a) Residence No. Preston & Valley Sts. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (Write the word.) Widower

5a-If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Virginia

6-DATE OF BIRTH (month, day and year) 1837

7-AGE. 86 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer). 014

(c) Name of employer.

9-BIRTHPLACE (city or town). Frederick Co.

(State or Country). Maryland

PARENTS

10-NAME OF FATHER, John H. Emmell

11-BIRTHPLACE OF FATHER (city or town). —

(State or Country).

12-MAIDEN NAME OF MOTHER, Catherine Lease

13-BIRTHPLACE OF MOTHER (city or town).

(State or Country).

14- (Informant). Sister Florence

(Address). Preston & Valley Sts. C.

15- FILED OCT 9 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 7th 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Oct 7 1923

that I last saw h. alive on 10/6 1923

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebro Palegra

Auleto Scolosis

(Duration) ... yrs. ... mos. 10 ds

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Benson Ross M. D

10/7 1923 (Address) Guy & Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL. Oct 9th 1923

20-UNDERTAKER. H. C. Brauning Son Funeral Directors

ADDRESS 17 N.

Stamped: OCT 9 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Issued

Stamped: DEC 1 - 1923 Registrar.

ALL ITEMS MUST BE FILLED IN LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lane

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79757. 90 D 79757.

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1556 Richland St., 43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Lane

(Residence in Baltimore: No. 1556 Richland St. Ave. yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 70 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balt

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lays Lane

(Address) 2952 Harlem ave

Filed OCT 9 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaboulay Aneurism Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Street) Chas Norris M. D. (Coroner.)

1923 (Address) 3632 Orleans

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, 10 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E. Fay.

INSTRUCTIONS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be p

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79758

CERTIFICATE OF DEATH.

100-001

D 79758

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 E. Centre St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. James

(Residence in Baltimore: No. 108 E. Centre St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept. 5th, 1853
(Month) (Day) (Year)

7-AGE, 70 yrs. 0 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas Bradford

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Cromwell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah J. Wright daughter

(Address) 2367 McCulloh Street

OCT 9 - 1923

Filed ..... 191.....

ROBERT B. KRAUTER, Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1923 to Oct 6 1923, that I saw h[illegible] alive on Oct. 6 1923, and that death occurred, on the date stated above, at 5:55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 2 wks. ..... ds.

CONTRIBUTORY (Secondary) Paralysis Agitans

(Duration) ..... yrs. ..... mos. 2 ..... ds.

(Signed) W. F. Cam[illegible] M. D.

Oct. 7 23, 191... (Address) 1515 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct. 9th, 1923

20-UNDERTAKER J. H. Johnson

ADDRESS 1309 Druid Hill Ave.

PRINT IN INK—THIS IS A PERMANENT RECORD

Spaces must be filled. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. NAME must be WRITTEN IN FULL. DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79759

CERTIFICATE OF DEATH.

21 D 79759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 W. Fayette St. ST., 20 WARD)

2-FULL NAME Lillian Una Helmling

(a) RESIDENCE NO. 1829 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 0 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	21	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore News

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Harry Albert Helmling

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian May Eitemiller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Lillian Helmling (Address) 1829 W. Fayette St.

15 Filed OCT 9 - 1923, 19 ROBERT R. KRAUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to Oct 8, 1923, that I last saw h[illegible] alive on Oct 8, 1923, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) [illegible] M. D.

10-8 1923 (Address) 121 S. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Oct 11" 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1002 W. Balto St.

1-PLEASE WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79760

CERTIFICATE OF DEATH.

129 D 79760

1-PLACE OF DEATH [redacted] L. 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5212 York Road. ST., 27 WARD)

2-FULL NAME Elizabeth Ann Ashley

(a) RESIDENCE NO. 5212 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Ashley

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89.	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Allegheny County (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER William Cox

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant [redacted] (Address) Mrs. R.W.H. Weed - 5212 York Rd.

15 Filed OCT 9 - 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1921, to date, 19, that I last saw h[illegible] alive on Sept. 8, 1923, and that death occurred, on the date stated above, at 4.47 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (30 yrs. +),
Chronic nephritis (?)
Myocardial insufficiency (5 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gradual onset.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis Blood Pressure

(Signed) N.N. Mead, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Homestead Pa — DATE OF BURIAL Oct 9 19

20 UNDERTAKER George A. Smith — ADDRESS 1532 Pulton

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Robert W Newman Jr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 7976I

CERTIFICATE OF DEATH.

34 ✓ D 7976I

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Walton Newman Junior

(Residence in Baltimore: No. Childrens Hosp School St.; 1 yrs., ~~6~~ mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White American	Single

6-DATE OF BIRTH, March 9th, 1917
(Month) (Day) (Year)

7-AGE. 6 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Edgar Walton Newman Jr.

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Helena Marguerite Price

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar David Newman

(Address) Childrens Hospital School

15-

Filed OCT 9 - 1923, 19... ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1922, to October 1923, that I saw h[illegible] alive on October 1923, and that death occurred, on the date stated above, at 9.35 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine & R. Hip

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert W. Johnson M. D.

....., 191... (Address) 4 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death? At home in Virginia

Former or usual residence Winchester Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Winchester Va	Oct 10, 1923

20-UNDERTAKER Wilson Bros

ADDRESS 1231 W. Baltimore St.

NOTE—THIS IS A PERMANENT RECORD

Spaces must be filled. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very necessary. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79762 ✓ 128 D 79762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Bank ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Dieble

(a) RESIDENCE NO 2015 Bank ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Wm Zaleski
(Address) 2015 Bank St

Filed OCT 9 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by (the Inquiry / Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Followed by
Convulsions (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harold B. Norton M. D.
(Coroner.)
Oct 7th, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 10 192 3

20 UNDERTAKER Frank Graham Son

ADDRESS 1916 Eastlake Ave

Cor.—1-12-23—M&T—100 Bks. Only supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... in plain terms, so that it may be properly classified. Exact statement of OCCUPA- ... important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79763

CERTIFICATE OF DEATH.

100-001

D 79763

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2050 E. Hoffman ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Stupek

(Residence in Baltimore: No. 2050 Hoffman st St.; 1 yrs., — mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, July 29, 1923 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Stupek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Barbara Vavra

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Stupek

(Address) 2050 Hoffman st

15-

OCT 9 - 1923 ROBERT R. KRAUTER,

Filed ....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1923 to Oct 7 1923 that I saw h[illegible] live on Oct 7 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 9, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct 9, 1923

20-UNDERTAKER Frank Crockett — ADDRESS 1906 Eastlander

WITH UNFADING INK—THIS IS A PERMANENT RECORD

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

instructions on back of certificate.

Remarks Tumor

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79764

101-001

D 79764

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 27 WARD)

2-FULL NAME George Gray

(a) RESIDENCE NO. 525 Welcome Alley, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Sadie Gray
(Address) 525 Welcome Alley

15 Filed OCT 9 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Oct 6th, 1923, that I last saw h in alive on Oct 6th, 1923, and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-29-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Manninger, M. D.

10-6, 1923 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Dunkirk Md

DATE OF BURIAL 10-9 1923

20 UNDERTAKER Harris Funeral

ADDRESS Md

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

H UNFADING INK—THIS IS A PERMANENT RECORD. Every item of infor-

carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, *6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Pneumonia

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79765

CERTIFICATE OF DEATH.

113 D 79765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Hanover St., 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma M. Hildebrand

(a) RESIDENCE NO. 1831 Hanover ST., 23 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Dem. white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 4 1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. E. Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary E. Hause

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Wm. E. Hildebrand 53 Hanover St

Filed OCT 9, 19 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 5, 1923

that I last saw h alive on Oct 5, 1923,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardio Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Ch Campbell M. D.

Oct 6, 1923 (Address) 1677 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edon Hill — DATE OF BURIAL: 10-9 1923

20 UNDERTAKER: Est B Hasle — ADDRESS: 115 E Ward St

UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79766

Larkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Larkins Sq Hospital

CITY OF BALTIMORE: (No.) ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Larkins

(a) RESIDENCE NO. 1329 Whalent ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer Amer Line

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Tuzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Jesse Larkin
(Address) 1329 Whalent St

Filed OCT 9 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Rt Leg

(duration) yrs. mos. ds.

(Signed) C O Slade, M. D.
(Coroner.)
Oct 9 1923 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL Oct 9 1923

20 UNDERTAKER James A. Mills

ADDRESS 1323 Pennsylvania

PERMANENT RECORD. Every item of information must be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 79767

CERTIFICATE OF DEATH.

38

D 79767

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15 WARD)

2-FULL NAME Arthur Owens

(a) RESIDENCE NO. 1311 Gilmore St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Municipal Hospital Records.
(Address)

Filed OCT 9 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 19 23

17

I HEREBY CERTIFY, That I attended deceased from September 28 19 23. to October 5 , 19 23.

that I last saw him alive on October 5 , 19 23.,

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Chronic Nephritis

Left Hemiplegia (Hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Clarke G. Lo M. D.

10-6-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 10 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2519 Division

IMPORTANT. See instructions on back of certificates.

A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION only supplied.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, *6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributo y (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (second ary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79763

CERTIFICATE OF DEATH.

162

D 79763

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Church ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Sewell

(Residence in Baltimore: No. 13 E. Church St.; ....yrs., 7 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	

6-DATE OF BIRTH, March 7, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md. Baltimore.

PARENTS.

10-NAME OF FATHER, Geo. Sewell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Wilmyre Pascal

13-BIRTHPLACE OF MOTHER (State or Country), Philippine Islands

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Sewell (Father)

(Address) 13 E. Church St.

15- Filed OCT 9 - 1923, 19..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4 1923, to Oct. 8 1923, that I saw him alive on Oct. 8 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

.....
Malaria
.....
..... (Duration)....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration)....yrs.....mos.....ds.

(Signed) L. L. Sewell M. D.

Oct 8, 1923 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct 12, 1923.
20-UNDERTAKER	ADDRESS
Wm. Henry Smith	708 Dolphin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79769 ✓ D 79769

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Jesse Chesnen

(a) RESIDENCE NO. Balte Athletic Club WARD City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jesse T. Chesnen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sophie Lubkert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed OCT 9 - 1923 ROBERT R. KRAUTER Register

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 - , 1923, to Oct 8 , 1923.

that I last saw h[illegible]live on Oct 8 , 1923

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Luetic Endarteritis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Section of Brain

(Signed) Trevor Orben, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 10/10 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

INFORMATION MUST BE GIVEN PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Krumelbein

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79770

CERTIFICATE OF DEATH.

161-001 ✓ D 79770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 S Patt Pk ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Virginia Krumelbein

(a) RESIDENCE NO. 637 S Patt Pk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/17/23

7 AGE Years Months Days 1 If LESS than 1 day, 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Ferdinand Krumelbein

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Md

12 MAIDEN NAME OF MOTHER Viola Learfield Harford Co

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Virginia Krumelbein

(Address) 637 S Patt Pk

15 Filed , 19 Registrar

OCT 9 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 8, 1923,

that I last saw her alive on Oct 8, 1923

and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Premature Infant

6 mo Gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no (

What test confirmed diagnosis? Physical signs

(Signed) Manuel L Fischer, M. D.

, 19 (Address) 3325 Patt Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Oct 9 1923.

20 UNDERTAKER James D'Ignan & Son ADDRESS 1000 S. Paca St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Gottschalk.

Spec.—1-10-21—M&T—1500 Bks.

D 79771

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 79771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough Apt ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Gottschalk

(a) RESIDENCE NO. Eutaw Place & Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Gottschalk

6 DATE OF BIRTH (month, day, and year): June 23rd 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
62	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Liquor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Port Deposit Md

PARENTS

10 NAME OF FATHER: Albert Gottschalk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rose Ullman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Gidion

(Address): Madison & Eutaw

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10 , 1923 , to Oct. 8 , 1923, that I last saw him alive on Oct. 8 , 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman, M. D.

, 19 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom — DATE OF BURIAL: Oct 10th 1923

20 UNDERTAKER: Leonard Sondheim — ADDRESS: 1180 McHenry

INFORMANT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79772

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 ✓ D 79772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2932 Riggs Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Ensor

(a) Residence No. 2932 Riggs Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella A. Ensor

6-DATE OF BIRTH (month, day and year): June 29, 1865

7-AGE: 58 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer): Self 05 ✓

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Jesse A. Ensor

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Agnes Linton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14- (Informant): Mrs. Ella Bowen

(Address): 2932 Riggs Ave.

15- Dec'd ..... 19.. ROBERT R. KRAUTER Registrar.

OCT 9 - 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1923, to Oct 7, 1923, that I last saw him alive on Oct 7, 1923, and that death occurred, on the date stated above, at 10.05 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

10-8 1923 (Address) 108 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: Oct. 9, 1923

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 W. Balto St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

Cor.—1-12-23—M&T—100 Bks.

D 79773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-0039 V

D 79773

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Ed. Infirmary, WARD)

2-FULL NAME Henry Rineker

(a) RESIDENCE NO. 123 S. Wolfe St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4- 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Attended school.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Rineker

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Lindeman

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Henry Rineker
(Address) 123 S. Wolfe St.

15 Filed OCT 9 - 1923 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH Oct 6

16 DATE OF DEATH (month, day, and year) Oct 6 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
& Lacerated Abdomen
(duration) yrs. mos. ds.
Struck by Auto Truck

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Jno. B. Horton, M. D.
(Coroner)
Oct 8th, 1923 (Address) Curtis Bay Road, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Oct 10 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79774 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79774

101-6

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Morris

(a) RESIDENCE NO. 3800 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male White

4 COLOR OR RACE White

5 Single, ~~Married, Widowed~~, or ~~Divorced, (write the~~ word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER John W. Morris

11 BIRTHPLACE OF FATHER (city or town) Penna

(State or country)

12 MAIDEN NAME OF MOTHER Emma Bradley

13 BIRTHPLACE OF MOTHER (city or town) Penna

(State or country)

14 Informant Hospital Record

(Address)

15 Filed OCT 9 1923, 19 ROBERT R. KRAUS Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8- 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1923, to Oct 3, 1923.

that I last saw him alive on Oct 8, 1923,

and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H W Harper M. D.

, 19 (Address) St Agnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	10/9 1923

20 UNDERTAKER George W Conley ADDRESS Fulton & Fayette

INFORMATION CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 79775

CERTIFICATE OF DEATH.

43 D 79775

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE, No. St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nicholas

(a) RESIDENCE No. 2178 Druid Hill Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Katie Nicholas

6 DATE OF BIRTH (month, day, and year) Sept 18- 1866

7 AGE: Years 57 — Months — Days 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Joseph Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ellen Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed . 19 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28 . 1923 . to Oct 5 . 1923 .

that I last saw him alive on Oct 5 . 1923 .

and that death occurred, on the date stated above, at 3-40 P. m.

The CAUSE OF DEATH* was as follows:

Operation for Carcinoma Ani.
Shock from operation

(duration) two yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2178 Druid Hill Ave

Did an operation precede death? Yes Date of Oct. 5 - 1923

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Robert W. McKay, M. D.

10-6 . 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct 7 19 23

20 UNDERTAKER: Mrs. R. C. Elliott — ADDRESS: 1725 Eutaw

Information, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor. 1-12-28 MAT 100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79776

CERTIFICATE OF DEATH.

90 D 79776

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Mulliken St. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Banks

(a) RESIDENCE NO 1608 Mulliken St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Banks

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Robert Elliott
(Address) 1725 Ashland Ave

15 Filed OCT 9 1923, 192 ROBERT R. KRAUT Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(Found Dead Bed)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Collins (Coroner), M. D.

10/8/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct 9 192 3

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 79777

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1604 McCulloh ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Brown

(a) RESIDENCE No. 1604 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: Years 78; Months -; Days -; If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Rachel Cuny

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jamie Green

(Address): 1604 McCulloh St

15 Filed ..... 19 ..... Registrar

OCT 9 - 1923 ROBERT B. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1923, to Oct 6, 1923, that I last saw h[illegible] alive on Oct 6, 1923, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) history yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gibbs Albumen

(Signed) John E Stewart M. D.

, 19 (Address) 704 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 9 1923

20 UNDERTAKER: Mrs. R.G. Elliott

ADDRESS: 1725 E Baltimore

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Blks.

D 79778

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D 79778

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD)

2-FULL NAME Lucy Ross

(a) RESIDENCE NO. 3156 21½ ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Graham

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1923, to 10-6, 1923, that I last saw h alive on 10-6, 1923, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Chronic Nephritis

Syphilis (20 yrs.)

(duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ... mos. 6 hrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Jones, M. D.

10-7, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Eshland

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79779 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 GROVE ST. 25 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME VINCENT JOSEPH MILVNAS OR LEVONAS

(a) RESIDENCE No. 2214 GROVE Street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE 53 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.O.R.R.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Nokonw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant J. Levonas

(Address) 2214 Grove Street

15 Filed OCT 9 - 1923 16 ROBERT R. ARAUJER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8. 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Oct 7, 1923.

that I last saw him alive on Oct 7, 1923

and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

1 hr

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Walter Cot, M. D.

10/8. 1923 (Address) 647 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Oct 11- 1923

20 UNDERTAKER John Gobbins ADDRESS 1125 S. Eutaw St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

Duitscher

D 79780

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 79780

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ft. Sq Hospital ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta G. Duitscher

(a) RESIDENCE No. 2807 W. Balto ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Duitscher

6 DATE OF BIRTH (month, day, and year) Jan. 9-1837

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
86	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Holland
(State or country)

PARENTS

10 NAME OF FATHER Bernhard Rijpma

11 BIRTHPLACE OF FATHER (city or town) Holland
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Hilly

13 BIRTHPLACE OF MOTHER (city or town) Holland
(State or country)

14 Informant Peter J. Duitscher
(Address) 2801 W. Balto. St.

15 Filed OCT 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Burns

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) 4 yrs. mos. ds.

(Signed) Geo Clinton Radke, M. D.
(Coroner)

Oct 9 1923 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Oct. 17 1923

20 UNDERTAKER George L. Schwab ADDRESS 901 Ludlow.

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 79781 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79781

X/31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace L. Burger

(a) RESIDENCE NO. Irving Hill (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug. 6, 1907

7 AGE: Years 16 Months 2 Days 3

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inmate

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Hurbert B. Burger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Hattie Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Hospital Records

(Address)

15 Filed OCT 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1923, to Oct. 8, 1923,

that I last saw her alive on Oct. 8, 1923,

and that death occurred, on the date stated above, at 9 55 P.m.

The CAUSE OF DEATH* was as follows:

Acute Pyelo-Nephritis.

Multiple Kidney Abscesses.

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary): Diffuse Peritonitis.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 9-25-23.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington Park

DATE OF BURIAL 19

20 UNDERTAKER: Wm. J. Richardson Bro.

ADDRESS 1121 Bennett Place

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 79782

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 14 W. Hill St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Brown

(a) Residence No. 14 W. Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Bessie Brown

6-DATE OF BIRTH (month, day and year): July 14-1867

7-AGE: 56 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Not given

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Edna Brown

(Address): 14 W. Hill st

15- Filed OCT 9 - 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct, 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct, 4, 1923 to Oct 8, 1923

that I last saw him alive on Oct, 8, 1923

and that death occurred, on the date stated above, at 3 a, m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan Francken M. D.

10/9, 1923 (Address) 122 W. Lee st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Md Perkins Chapel Cem Funeral — DATE OF BURIAL: Oct 9 1923

20-UNDERTAKER: F. A. Krause & Son — ADDRESS: 763 Hanover St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79783 D 79783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Gundry Sanitarium Athol P.O. Arlington Cantonsville

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Forest Manor ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ruth S Hood

(Residence in Baltimore: No. Gundry Sanitarium St.: 14 yrs., ~ mos. ~ ds.)

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ..., 1851
(Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore County Md

PARENTS.

10-NAME OF FATHER, Charles Shipley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary George

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred J. Gundry M.D.

(Address) Athol Cantonsville

15- OCT 9 1923 ROBERT R. KRAUTER,
Filed ..... 1..., 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1909, to Oct 8 1923, that I saw h alive on Oct 8 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Urinary Bladder

..... (Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Hemorrhage Internal

..... (Duration) ....yrs. ....mos. 9 ds.

(Signed) Alfred J. Gundry M. D.

Oct 8, 1923 (Address) Athol Cantonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 14 yrs. 1 mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Gundry Sanitarium Athol

Former or usual residence Baltimore Co Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	Oct. 10., 1923

20-UNDERTAKER	ADDRESS
Jos Sounders Son	2178 Penn

Spec.—1-10-21—M&T—1500 Bks.

D 7978½ HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 7978½

X 146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green STS 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Green

(a) RESIDENCE NO. White Hall Md ST., WARD Maternity

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 19 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): White Hall Md Baltimore Co.

PARENTS

10 NAME OF FATHER: Thomas C. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sally Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Hospital Records

15 Filed OCT 9 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 9, 1923,

that I last saw h e alive on Oct 9, 1923,

and that death occurred, on the date stated above, at 9.30 am.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

Following Ovarian Section

Streptococcus & Colon organism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of Oct 4-1923

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) W. Wallace Walker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: White Hall Md. Town Line Pa

DATE OF BURIAL: 19

20 UNDERTAKER: P. Washington

ADDRESS: White Hall Md

CTS-1923

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79785

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 N. Parrish ST. 16 WARD)

2-FULL NAME Freddie Pleasant

(a) RESIDENCE NO 1213 N. Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about Aug. 1923 Given

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Estelle Pleasant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lillie May Adams
(Address) 1213 N. Parrish St.

15 Filed ... 2 ... 192 Robert J. Morrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pleis-Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Oct. 5, 1923 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

OCT 9 1923 JOHNS HOPKINS HOSPITAL

TION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 79786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79786

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Willes

(a) Residence No. 621 Greenwillow st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1888

7-AGE: 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Georgia

PARENTS:

10-NAME OF FATHER: King Willes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Georgia

12-MAIDEN NAME OF MOTHER: Lizzie ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

11- (Informant): Hospital Records

(Address): M.T.H.

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 1923 to Oct. 6 1923

that I last saw h. im alive on Oct. 6 1923

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D.

10-6 1923 (Address) Municipal Tbc. Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. ADDRESS

Robert E. Garrison, Burial Permit Clerk.

Commissioner of Health.

OCT 9-1923

OCT 9-1923

Please be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

146522 D 79787

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 79787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME ~~James~~ Shirley Jones

(a) RESIDENCE NO. 1915 Penna. Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~Husband of~~ Wife of: .....

6 DATE OF BIRTH (month, day, and year): May 4, 1923.

7 AGE — Years: — Months: 4 Days: 21 If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): #

(c) Name of employer: #

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Walter Shirley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Elsie Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed OCT 9 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Sept 30, 1923, that I last saw h[illegible] alive on Sept 30, 1923, and that death occurred, on the date stated above, at 1 4. m.

The CAUSE OF DEATH* was as follows:

Syphilis, early hereditary

(duration) yrs. life mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Wassermann

(Signed) H. H. Weed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: .....

DATE OF BURIAL: 19

20 UNDERTAKER: .....

ADDRESS .....

Robert P. Garrison, Commissioner Health.

OCT 9-1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79788

D 79788

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths' Home Chemnt Hill Ave ST.; 9 WARD)

2-FULL NAME Adelaide Earl

(a) RESIDENCE. No. St. Elizabeths' Home - Chemnt Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): April 15 1923

7 AGE — Years | Months: 4 | Days: 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Crownsville Md.

PARENTS

10 NAME OF FATHER: John Earl

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Gleadova Swann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address)

15 Filed OCT 9 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 6 1923

17

I HEREBY CERTIFY, That I attended deceased from September, 1923, to October 5, 1923, that I last saw h[illegible] alive on October 5, 1923, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Oct 7, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

Commissioner of Health. OCT 8 1923

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79789

168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Francis. (C)

(a) RESIDENCE NO Maryland Penitentiary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Maryland Penitentiary
(Address) Bureau of Identification.

15 Filed 19-1923, 192 Robert P. Harrison, Registrar

16 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging.
Mentally unbalanced.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas. E. Reinhardt, M. D.
(Coroner)

Oct 8, 192 3 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL 192

20 UNDERTAKER ADDRESS

THE MORGUE

UNIVERSITY OF MARYLAND

Commissioner of Health.

Per. Wm. E. Woodall

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79790 90 D 79790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1966 Patterson Pl ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Lemmon

(a) RESIDENCE No. 1966 Patterson Pl ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Feby. 10th 1893

7 AGE: Years 30 | Months 7 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Charles E Lemmon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto city

12 MAIDEN NAME OF MOTHER: Mary A. Tress

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Katherine Manner

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Oct 9th, 1923, that I last saw him alive on Oct 8th, 1923, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Coma & Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alb. L. Lee, M. D.

Oct 9, 1923 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Bedell. DATE OF BURIAL: Oct 12 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 E North.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79791

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 E. Hughes St. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Dinse

(a) RESIDENCE. NO. 109 E Hughes ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 21 - 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Max Dinse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Dinse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Max Dinse (Address) 109 E. Hughes st

15 Filed ..... 19 ..... Registrar

T9 - 1923 Robert V. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-1-23, 19..., to 10-8-23, 19..., that I last saw her alive on 10-8-23, 19..., and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris, M. D.

10.9.23 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 11 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

D 79792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79792

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH 13 Lohrs Lane

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo N. Martin Jr

(a) RESIDENCE No. 13 Lohrs Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? U. S. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Sept 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leo N. Martin Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elmira Rukstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs Tessie Martin

(Address) 13 Lohrs Lane

15 Filed ....., 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk

OCT 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923 to Oct 8, 1923.

that I last saw h~~e~~ive on Oct 8, 1923

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Gallopping Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Fatty degeneration of heart Myocarditis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 13 Lohrs Lane

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. F. Gardner, M.D.

, 19 (Address) 3326 Fredrick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 10, 1923
20 UNDERTAKER	ADDRESS
Wm Tenk	2057 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 79793

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 Scott St ST., 16 WARD)

2-FULL NAME Margaret G. Adams.

(a) RESIDENCE NO. 102 Scott St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 21 1905

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
17	11	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): 6/10

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Edward F. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs E. G. Adams. 102 Scott St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk

CT9 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 6. 1923 to Oct 7 1923

that I last saw her alive on Oct 6 1923

and that death occurred, on the date stated above, at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 6. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Smiley M. D.

10/8, 1923 (Address) 601 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 10 1923
20 UNDERTAKER Edward Howe	ADDRESS
Edward Howe	901 Hollins St

IMPORTANT—WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79794

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1732 Ruxton St. Gard WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abram M. Packolder

(a) RESIDENCE NO. 1732 Ruxton St. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fanny Packolder

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 58 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tobacco Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Morris Packolder

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Emma Packard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Fanny Packolder

(Address) 1732 Ruxton Ave

OCT 9 - 1923

Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 20 - , 1923, to Oct 8 , 1923.

that I last saw h alive on Oct 8 1923,

and that death occurred, on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Angina Pectoris

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) —yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) Elmer B Brennan M. D.

, 19 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem

DATE OF BURIAL: 10/10 1923

20 UNDERTAKER: J Abrams

ADDRESS: 16 N Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 79795

CERTIFICATE OF DEATH.

31 D 79795

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 424 W 25 St ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Stuart

(a) RESIDENCE. No. 424 W 25 St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 1871

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sallie Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fannie Stuart (Address) 424 W 25 St

15 Filed OCT 9 - 1923, 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Oct 9, 1923, that I last saw h[er] alive on Oct 9, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Richardson, M. D.

Oct 9, 1923 (Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL Oct 12 1923

20 UNDERTAKER CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE.

CERTIFICATE SHOULD BE CAREFULLY PREPARED, AS IT IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79796 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79796

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Wallbrook Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas Tracy

(a) RESIDENCE NO. 2223 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Tracy

6 DATE OF BIRTH (month, day, and year) March 14, 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Tracy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Steffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W. S. Tracy (Address) 2223 Wallbrook Ave

15 Filed OCT 9 1923, 19 Robert F. Garrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9th 1923.

17 I HEREBY CERTIFY, That I attended deceased from September 2nd, 19 23 to October 9th, 19 23.

that I last saw him alive on Oct. 1st, 19 23.

and that death occurred, on the date stated above, at about 6 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) 2 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? General condition

(Signed) O. H. Hoffman, M. D.

10/9, 19 23 Address) 3402 Wallbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Cemetery — DATE OF BURIAL Oct 11, 1923

20 UNDERTAKER E. L. Steffler — ADDRESS 125 [illegible]

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79797 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79797

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3709 Springdale Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene P. Pennington

(a) RESIDENCE No. 3709 Springdale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Pennington

6 DATE OF BIRTH (month, day, and year) Dec 8. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banking business

(b) General nature of industry, business, or establishment in which employed (or employer) Mer. P. C.

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. S. Pennington

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah A. Hackam

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Margaret E. Pennington
(Address) 3709 Springdale Ave

15 Filed CT 9 1923, 19 Robert J. [illegible] Burial Permit Clerk

Registrar John O. Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Oct 8, 1923.

that I last saw him alive on Oct 5, 1923,

and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Hebert M. D.

10/9 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sudlersville Md | DATE OF BURIAL Oct 11 1923

20 UNDERTAKER John O. Mitchell | ADDRESS 120 W. Fayette St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D 79793 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79793

6657

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 11 WARD)

2-FULL NAME Cecil C. Buckman

(a) RESIDENCE NO. Hotel Belvidere ST., WARD Baltimore Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Edward S. Buckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Elizabeth Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed , 19 Registrar

1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1923, to Oct 8, 1923, that I last saw him alive on Oct 8, 1923 and that death occurred, on the date stated above, at 10:52 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis,

Arteriosclerosis.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) General Paresis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Section

(Signed) Trevor Owen M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Oct. 10 1923

20 UNDERTAKER John Ottotchel ADDRESS 1201 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T9

D 79799

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D 79799

1 PLACE OF DEATH

Registered No. C

CITY OF BALTIMORE (No. 2819 N. Calvert St. 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary L. Michael

(Residence in Baltimore: No. 2819 N. Calvert St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: June 5, 1857 (Month) (Day) (Year)

7 AGE: 66 yrs. 4 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Peter Nagle

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hoffman

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard O. Michael Jr.

(Address) 2819 N. Calvert St.

15 Robert P. Harrison,

Filed ....., 191.... REGISTRAR

OCT 9-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 8th, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1923. to Oct 8th 1923

that I saw h[illegible] alive on Oct 5th 1923

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Chronic Bronchial Pneumonia

Chronic Endocarditis

..... (Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY) Acute Cardiac Dilatation

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Frederick D. Crum M. D.

Oct 9, 1923 (Address) 2827 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cherryman Md. DATE OF BURIAL: Oct 11, 1923

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W. Fayette St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79800

D 79800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 W Lexington ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha B. Turner

(a) RESIDENCE NO. 1421 W Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas T. Turner.

6 DATE OF BIRTH (month, day, and year) Mch 27 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83.	6.	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John P. Brotherton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Louisa Bodensick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Frank Turner

(Address) 1421 W Lexington St.

15 Filed OCT 9 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1923, to Oct 8, 1923,

that I last saw her alive on Oct 8, 1923,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo. T. Kemp, M. D.

, 19 (Address) St James Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct. 10, 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79801 ✓ D 79801

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Newton

(a) RESIDENCE NO. 223 Cole Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	--		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Municipal Hospital (Address)

15 Filed OCT 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from September 5, 1923, to October 8, 1923, that I last saw her alive on October 8, 1923, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma (duration) yrs. 6 mos (Estimated) ds.

CONTRIBUTORY (Secondary) Bronchor Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Horne, M. D.

10-8-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 11 1923

20 UNDERTAKER Schamel & Cordes

ADDRESS 1024 Aisquith St

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Neck—both pulse

D 79802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79802

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2642 Harlem Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Steil

(Residence in Baltimore: No. 704 Cathedral St. St.; yrs. 6 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. November 25 1864
(Month) (Day) (Year)

7-AGE. 58 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired) 0

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Louis Steil

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Miss Schueler

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bertha C. Steil

(Address) 4013 Walrad Ave.

15-

Filed OCT 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

10-8 1923 (Address) 2302 Eamondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cem	Oct. 10" 1923
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Bals St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79803 — 123 — D 79803

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Pennsylvania Ave ST., 14 WARD)

2-FULL NAME Amelia Noyes

(a) RESIDENCE NO. 1802 Pennsylvania Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William L. Noyes

6 DATE OF BIRTH (month, day, and year) Mar. 17, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Mr. Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mr. Wm. L. Noyes 1802 Pennsylvania Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1923 to Oct 7 1923, that I last saw h[illegible] alive on Oct. 7 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Gradual failing, no special disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Mal digestion

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

10-8 1923 (Address) 1605 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Oct. 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Balto

OCT 10 1923 ROBERT P. KRAUTER, Registrar

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

old lady blind for some years had gallstone colic several times and, max exposure. No actual disease great gradual failing.

Ed Spruit MD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 79804

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 Harford Ave St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Martin P. O'Leary.....

(a) Residence No... 922 Harford Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. 3 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 23rd 1923

7-AGE, — yrs. 3 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0 0

(c) Name of employer.....

9-BIRTHPLACE (city or town).... Ellis
(State or Country),

PARENTS.

10-NAME OF FATHER, Martin O'Leary

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Edeth Prediger

13-BIRTHPLACE OF MOTHER (city or town)... Ellis
(State or Country),

14- (Informant) Mrs Edith O'Leary

(Address) 922 Harford Ave

15- Filed OCT 10 1923 By ROBERT R. KRAUSE Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9th 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 7th 1923 to Oct 9th 1923

that I last saw him alive on Oct 9 1923

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

..... (Duration) .... yrs. .... mos. 11 ds

CONTRIBUTORY (Secondary) Asthma

..... (Duration) .... yrs. .... mos. .... ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. McCarter M. D.

Oct 9th, 1923 (Address) 111 W Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Bonnie Brae — DATE OF BURIAL, Oct 11 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sophia Randolph

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79805 — 74-001 — D 79805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 Leadenhall St. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Randolph

(a) RESIDENCE. No. 944 Leadenhall St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Randolph

6 DATE OF BIRTH (month, day, and year): Aug 25 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: David Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cresie Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John Randolph
(Address): 944 Leadenhall St.

15 Filed . 19 . Registrar

OCT 10 1923

ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to Oct 4, 1923

that I last saw her alive on Oct 3, 1923

and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Cerebral Hemorrhage

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 5 mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. F. Reinhardt, M. D.

Oct 4, 1923 (Address) 712 Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Oct 11 1923
20 UNDERTAKER: S. H. Bloom & Son	ADDRESS: 108 W. Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 79806 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 79806

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Edward Gallagher

(a) RESIDENCE NO. 925 Valley. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair mender 014

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Samuel Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Bay View Hospital

15 Filed OCT 10 1923 Registrar Hauck

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Oct. 9, 1923, that I last saw living on Oct. 9, 1923, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Terminal)
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute alcoholism
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. Goldsmith M. D.

10/9/1923 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Burial Park — DATE OF BURIAL Oct 12 1923

20 UNDERTAKER Henry Hoech Son — ADDRESS 1301 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+179 D 79807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lula Fed

(a) RESIDENCE No 822 Stirling St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 7 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PHYSICIANS should state ... Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Greenwood S.C.
(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Fed.

11 BIRTHPLACE OF FATHER (city or town) S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mattie Locke

13 BIRTHPLACE OF MOTHER (city or town) S.C.
(State or country)

14 Informant Mattie Locke
(Address) 822 Stirling St.

15 Filed OCT 10 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns over body, arms and neck.
Accidental- child was playing with matches and clothind caught fire.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) S H Pace, M. D.
(Coroner)
10/9/23 192 (Address) 501 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Greenwood S.C.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood S.C. DATE OF BURIAL 10/10 1923

20 UNDERTAKER Robert Wilkes ADDRESS 1517 McElderry St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 240 S Edwd St. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rachael Yanofsky

(a) Residence No. 240 S Edwd St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. housework
(b) General nature of Industry, business, or establishment in which employed (or employer). 037
(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Hershel Yanofsky

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Bailey Furman

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Russia

14- (Informant) Sons (Address) 1429 E. Pratt

15- Filed 192 Registrar.

OCT 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-9-23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923 to Oct. 6, 1923

that I last saw h. alive on Oct 6 1923

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia
(Achylia gastrica probably associated with Gastric cancer (?))
(Duration) About 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Diabetes
Coma food
(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? cf. Mt. Sinai Hosp. Records

X (Signed) Rachael Fruaton M. D.

X 9, 1923 (Address) 927 S. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Sinai Cemetery — DATE OF BURIAL, Oct 12, 1923

20-UNDERTAKER. — ADDRESS East Lewis, 1429 E Pratt

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79809

CERTIFICATE OF DEATH.

168 D 79809

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2107 Edmondson Av ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Plawansky

(Residence in Baltimore: No. 2107 Edmondson Av St.; 20 yrs., mos. ds.)

Type or print information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1886 (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron-Worker
(b) General nature of industry, business, or establishment in which employed (or employer): D3

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Samuel Plawansky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Plawansky (Wife)

(Address) 2107 Edmondson Av

15-

Filed OCT 10 1923 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Rope)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct 10, 1923 (Address) 2802 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Oct. 12, 1923

20-UNDERTAKER Jos T Lewis ADDRESS 1439 E Pratt

Spec.—1-10-21—M&T—1500 Bks.

D 79810 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D 79810

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 Wauche ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Borden

(a) RESIDENCE NO. 325 Wauche ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years 44 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Pauline Cooper

(Address) 325 Wauchope St

15 Filed OCT 10 1923 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to Oct 7 1923

that I last saw h alive on Oct 6 1923

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Arrest Collapse

(duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Signs

(Signed) Chas H. Friedman M. D.

1923 (Address) 512 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 10 1923

20 UNDERTAKER: Samuel Kennedy

ADDRESS: Madison

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 7981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-502 ✓

D 7981

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 203 N. Dallas ST.: 6 WARD)

2-FULL NAME Annie Johnson

(a) RESIDENCE. No. 203 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jacob Johnson
(Address) 203 N. Dallas

15 Filed OCT 10 1923 19 ... Registrar

ROBERT P. KRAUTER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Oct 9, 1923, that I last saw h... alive on Oct 8, 1923, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clyde Dunn M. D.

Oct. 10 1923 (Address) 2017 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	10/12th 1923

20 UNDERTAKER ADDRESS

Jas. M. Skinner 1625 E. Madison st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79812 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79812

CERTIFICATE OF DEATH.

25 45

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 111 N.First St.Brooklyn St., 25 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen W.Ireland

(a) Residence No. 111 N.First St.Brooklyn St., Ward (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Ireland

6-DATE OF BIRTH (month, day and year) April 28 1903

7-AGE 20 yrs. 5 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Elec.Welder 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Copper & Iron Wks.

(c) Name of employer Curtis Bay Md.

9-BIRTHPLACE (city or town) (State or Country), Anne Arundel Co. Md.

PARENTS

10-NAME OF FATHER, George L.Ireland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Anne Arundel Co.Md.

12-MAIDEN NAME OF MOTHER, Gertie W.Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Anne Arundel Co.Md.

14- (Informant) Gertie W.Ireland(Mother)

(Address) 111 N.First St,Brooklyn

15- Filed OCT 10 1923 192 OCT 10 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct.9 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 1923, to Oct 9 1923

that I last saw h— alive on Oct 8 1923

and that death occurred, on the date stated above, at 2.10 A.m.

The CAUSE OF DEATH* was as follows:

Cancer of Colon

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brook M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Calvary Church Cemetery A.A.Co. Md. Via Auto

DATE OF BURIAL Oct 11 1923

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79813

CERTIFICATE OF DEATH.

49 D 79813

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 302 Carroll Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orrill Oscar Robinson

(a) Residence No. 302 Carroll Rod St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie N Robinson

6-DATE OF BIRTH (month, day and year) June 1871

7-AGE. 52 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy

(c) Name of employer R. M. P. Co Balto. Md

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Lewis H Robinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary A Rust

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Mrs H W Robinson

(Address) 302 Carroll Road

15- Filed OCT 10 1923 19.. ROBERT R. KRANTZ Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9-1923

17- I HEREBY CERTIFY, That I attended deceased from Apr 5 1923 to Oct 9 1923.

that I last saw him alive on Oct 9 1923

and that death occurred, on the date stated above, at 6.45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Lung 2½ hrs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 5 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation & Microscopic

(Signed) L Rowe Price, M. D

19 (Address) Glyndon Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Oct 11 1923

20-UNDERTAKER George J Smith ADDRESS 1532 Hollins St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ...information ...should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec—12-23-21—E.B.R.S.—400 Bks.

Sanloro

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79814

CERTIFICATE OF DEATH.

161-001 V

D 79814

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 214 S. Edw. St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Peter Sanloro

(a) Residence No. 214 S. Edw. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6-DATE OF BIRTH (month, day and year) Oct 1 23

7-AGE, ...yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Michael Sanloro

11-BIRTHPLACE OF FATHER (city or town)... Italy
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Volo

13-BIRTHPLACE OF MOTHER (city or town)... Italy
(State or Country),

11- (Informant)... Michael Sanloro

(Address)... 214 S. Edw.

15- 1 Oct. OCT 10 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9. 23

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 9, 1923, that I last saw h... alive on Oct 4, 1923, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Pertussis due to
Pneumonia Bilateral
6 months Duration

.....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

.....(Duration)....yrs....mos....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical Observation

(Signed) 14 S. Broadway, M. D.

Oct 10, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL, Oct 10, 1923

20-UNDERTAKER, Wendell Apfel & Co — ADDRESS 3781

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79815

65-09

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Franklin St. WARD 19)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Joseph Hunt

(a) RESIDENCE NO. 1509 N. Franklin St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Mar. 28-1917

7 AGE — Years: 6 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Tamara J. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Cora Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Tamara J. Hunt

(Address): 1509 N. Franklin St.

15 Filed OCT 10 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to Oct. 8, 1923, that I last saw him alive on Oct 8, 1923, and that death occurred, on the date stated above, at 6 45 p. m.

The CAUSE OF DEATH* was as follows:

A. Leukemic Leukemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Homer L. Todd, M. D.

10/8, 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 10/11 1923

20 UNDERTAKER: J. A. Moran

ADDRESS: 3100 E. Biddle

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 79816

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 244 S. Collington ave. (ST.,) 1 (WARD)

2-FULL NAME Mary Knox

(a) RESIDENCE NO. 244 S. Collington ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard T. Knox

6 DATE OF BIRTH (month, day, and year): Sept. 8th 1856

7 AGE: Years 67 | Months 1 | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thos. Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary Knox 244 S. Collington ave

15 Filed , 19 Registrar

OCT 10 1923 Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 , 19 23 , to Oct 7 , 19 23

that I last saw h[illegible] alive on Oct 7 , 19 23

and that death occurred, on the date stated above, at 1 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic cholecystitis

about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Valvular heart disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Leo Keller , M. D.

10. 9. 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: 10/11 1923

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore St

D. 79817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 79817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ocie Mae Mitchell

(a) RESIDENCE NO. Mt. Airy, ST., WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 1912

7 AGE — Years: 11 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER Della J

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed , 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CT 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1923, to Oct 10, 1923, that I last saw h[illegible] alive on Oct 10, 1923 and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)
Septicemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry, blood culture, urine analysis

(Signed) Casper Lucas, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rose Hill — DATE OF BURIAL: 10/10 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79813

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Beacham.

(a) RESIDENCE NO. Church Home & Infirmary ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elisha J. Beacham

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: Abt 75 | Months: — | Days: — | If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Last known

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Hosp Record Church Home & Inf

Filed ..... 19 ..... Registrar

Robert T. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1923, to Oct 9, 1923, that I last saw h alive on Oct 9, 1923, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Mitral and Aortic Insufficiency

Nephritis Chronic

(duration) 2 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Microscopic autopsy

(Signed) Captain Pancoast M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: National Cem Washington D.C

DATE OF BURIAL: 10/11 1923

20 UNDERTAKER: Chas P. Graul & Son

ADDRESS: 18 W. Mt Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79819 D 79819 129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of St. Francis 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Christie

(a) Residence No. Preston & Caroline Sts St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 1849

7-AGE. 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Gld

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country).

PARENTS

10-NAME OF FATHER, Michael Christie

11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country).

12-MAIDEN NAME OF MOTHER, Mary Gorman

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country).

14- (Informant) Sister Florence

(Address) Preston & Caroline Sts

15-

Filed ..... 192.. Registrar.

T 101923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/10/23

17- I HEREBY CERTIFY, That I attended deceased from 10/3 1923 to 10/10 1923

that I last saw h. alive on 10/10 1923

and that death occurred, on the date stated above, at 3:52 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis deceased

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wolff M. D

10/10 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem DATE OF BURIAL. Oct 11 1923

20-UNDERTAKER, H. C. Weidefeld ADDRESS 914 Greenmount ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79820 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 79820

CERTIFICATE OF DEATH. × 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ✓ ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Asther.

(a) RESIDENCE NO. U.S. Marine Hospital No 1 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 37 Months — Days —

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman - cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Otto Asther, U.S.M.H.

15 Filed OCT 01923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1923, to Oct. 10, 1923, that I last saw him alive on Oct 10, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary, Chronic, active.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No - Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) M. A. Fuller, M. D.

19 (Address) U.S. Marine Hospital No 1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: 10/10 1923

20 UNDERTAKER: Sol Levinson & Bro. — ADDRESS: 1127 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Martinsen) Martinsen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79821

CERTIFICATE OF DEATH.

X 90 D 79821

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Martinsen

(a) RESIDENCE No. U.S. Marine Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	"	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman - Foetsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant A. Martinsen (Address) 716 Flamer st

15 Filed 10/10 19 23 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1923, to Oct. 9, 1923, that I last saw h— alive on Oct 9, 1923 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

Mitral regurgitation, with mitral

Stenosis (duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? M. D. Foster

(Signed) M. D.

10/9 1923 (Address) U.S. Marine Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery DATE OF BURIAL 10/10 1923

20 UNDERTAKER J. Lippincott Bro ADDRESS 1127 E Balto St

CAUSE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10/1923

Spec.—1-10-21—M&T—1500 Bks.

(Sudhup)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79822

CERTIFICATE OF DEATH.

160

D 79822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 75 N. Holbrook ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma May Sudhop

(a) RESIDENCE NO. 75 N Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltr.
(State or country)

PARENTS

10 NAME OF FATHER John Sudhops

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Alma Crumpler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mr John Sudhop
(Address) 75 N Holbrook

15 Filed ....., 19 .....

Robert P. Harrison,
Registrar

T 01923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1923 to Oct 10 1923.

that I last saw h W alive on Oct 10 1923

and that death occurred, on the date stated above, at 11.25 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible], M. D.

, 19 (Address) 11 No Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wod River Md — DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Lan

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in for CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Debility

D 79823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79823

CERTIFICATE OF DEATH.

X 188-003

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hosp. ST. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles H. Akehurst

(Residence in Baltimore: No. 6076 Falls Road St.; yrs., mos. 1 ds.)

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Aug. (Month) 19 (Day), 1917 (Year)

7-AGE, 6 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Co.

PARENTS.

10-NAME OF FATHER, Charles L. Akehurst

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER, Mary A. Bumgardner

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas L. Akehurst

(Address) 6076 Falls Road

15- Filed 10 1923, 191.... Robert P. Harrison, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull
automobile accident

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

Oct. 10, 1923 (Address) 2502 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Dyer Ridge DATE OF BURIAL, Oct. 11, 1923

20-UNDERTAKER, A. B. Marshall ADDRESS, 359 Fallsway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 79824

D 79824

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. . ST., 11 WARD)

2-FULL NAME Frieda Waters

(a) RESIDENCE NO. 849 Hamilton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): May 7 - 1923

7 AGE — Years: — Months: 5 Days: 5 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thomas Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Frieda Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hampton Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed OCT 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to Oct 9, 1923, that I last saw him alive on Oct 9, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, Congenital

Acute Nephritis (syphilitic)

~~Acute Intestinal~~

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Acute Intest. Indigestion (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann T. R. Urine Analysis.

(Signed) Casper Goodpasture, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Samuel J. Brune & Co. ADDRESS: Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79825

CERTIFICATE OF DEATH.

90 D 79825

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

2-FULL NAME Elizabeth Cornish

(a) RESIDENCE No. 716 Sarah Ann St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state every item of information carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Cornish

6 DATE OF BIRTH (month, day, and year) 10/21/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Jim Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Rena Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: James Cornish (Address) U. S. Navy

15 Filed . 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 8, 19 23, to October 9, 19 23, that I last saw h[illegible] alive on October 8, 19 23, and that death occurred, on the date stated above, at 7:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) Harry E. Handley M. D.

19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Oct. 12 19 23

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1309 Druid Hill Av.

D 79826

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

D 79826

REGISTERED No. C

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 707 George St. WARD 17)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon V. Bradford

(Residence in Baltimore: No. 707 George St. St.: 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Feb. 18, 1881 (Month) (Day) (Year)

7 AGE: 42 yrs. 7 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Bellman
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: John E. Bradford

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Agnes B. Smith

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes B. Bradford

(Address) 1202 Druid Hill Ave.

15 Filed OCT 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk

, 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 8, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1923 to Oct 8 1923 that I saw him alive on Oct 8, 1923 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Chronic Alcoholism (Duration) yrs. mos. ds.

(Signed) T. Strunkenhoff M. D.

, 191 (Address) 1202 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct. 11th, 1923

20 UNDERTAKER: J. W. M. Johnson — ADDRESS: 1309 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

D 79827 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 D 79827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Marshall ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnore Virginia Smith

(a) RESIDENCE NO. 1216 Marshall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 21. 1923

7 AGE — Years: | Months: 1 | Days: 18 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Walter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Laura McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md.

14 Informant: Walter Smith (Father)

(Address) 1216 Marshall St.

15 Filed OCT 11 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/23 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Oct 9, 1923, that I last saw h[illegible] alive on Oct 9, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia Chills
7 h Multiple Infection

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypo Pneumonia

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Moll M. D.

Oct 10/23 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Margaret L. Flynn

ADDRESS 1402 Light

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 79828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00V

D 79828

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Queen Ann Road St.) (15 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Hinze Schmidt

(a) RESIDENCE. No. 8 Queen Ann Road St., Ward.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Adolph ~~Hinz~~ Hinze

6 DATE OF BIRTH (month, day, and year): April 17/1838

7 AGE: Years 85 Months 5 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christian Lerz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magelene Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Stahloff

(Address) 8 Queen Ann Road

15 Filed ..... 19..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1923, to Oct 10th, 1923, that I last saw her alive on Oct 9th, 1923, and that death occurred, on the date stated above, at 12.06 A m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual Clinical Tests

(Signed) D. W. Keown, M. D.

10/10/1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 12 1923

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Hampe.

D 79829

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

(80) D 79829

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 602 Bartlett ave. St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Hampe

(Residence in Baltimore: No. 602 Bartlett ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~ MARRIED ~~WIDOWED OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: Jan 26th (Month) (Day), 1874 (Year)

7-AGE: 49 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Sole Muffler & Co.

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Wm F. Hampe.

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Laura Gorsuch.

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Hampe

(Address) 602 Bartlett Ave

15- Filed OCT 11 1923, 191 ROBERT R. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 8th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8th, 1923, to, Oct 8th 1923, that I saw h~~er~~ alive on Oct 8th 1923, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Myocarditis

(Duration) yrs mos ds.

(Signed), F. J. Sankin M. D.

10/9/23, 1923 [Address] 119 N. Milton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Oct 11th 1923

20-UNDERTAKER: Leo E. Cook

ADDRESS: North & Harford Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied. PHYSICIANS should

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 79830

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 ✓ D 79830

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 102 Dorchester Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Baer

(a) RESIDENCE. No. 102 Dorchester Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie E. Baer

6 DATE OF BIRTH (month, day, and year): March 24, 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Newton Pa

PARENTS

10 NAME OF FATHER: George A Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick md

12 MAIDEN NAME OF MOTHER: Sarah Mullette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mary Baer
(Address) 102 Dorchester ave

15 Filed OCT 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit (illegible)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30th, 1923, to October 9th, 1923, that I last saw h[illegible] alive on October 8th, 1923, and that death occurred, on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis ?
Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. W. Linton Clift, M. D.

Oct 9, 1923 (Address) 312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Oct 12 1923

20 UNDERTAKER: James Boyd & Son

ADDRESS: 1324 Eutaw

REGISTRATION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

Burton Rohart

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

166139

X 65-001 D 79831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. D 79831

CITY OF BALTIMORE: (No. D 79831 ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burton Rohart

(a) RESIDENCE NO. Winburne, Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single ?

6 DATE OF BIRTH (month, day, and year): —?—

7 AGE: Years: about 23 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): ? Pa.

PARENTS

10 NAME OF FATHER: Stephen R.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Christoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed OCT 11 1923 19 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Oct 10, 1923, that I last saw h alive on Oct 10, 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Leukaemia, myeloblastic

(duration) yrs. 3 mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Warfield M Foster M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesburg Pa. DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Wm. Leech & Son ADDRESS: 5 Zoo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 79832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1548 D 79832

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Metau V. Baltzell

(a) RESIDENCE. NO. 1807 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: McClellan L. Baltzell

6 DATE OF BIRTH (month, day, and year): Dec 16 1863

7 AGE — Years: 59 — Months: 9 — Days: 23 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Thurmont Md.

PARENTS

10 NAME OF FATHER: Calvin L. Weller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emily A Favorite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: McClellan L. Baltzell
(Address): 1307 Mosher St.

15 Filed OCT 11 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Oct 9, 1923, that I last saw h alive on Oct 9, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma

(duration) yrs. 2. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Aug 1-23

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical

(Signed) J Thomas Tulloss, M. D.

19 (Address) 1001 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL OR CREMATION: Thurmont Md. — DATE OF BURIAL: Oct 12 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Umbilicus

Spec.—1-10-21—M&T—1500 Bks.

Dr Vinroup
130 N Loudon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79833

CERTIFICATE OF DEATH.

57

D 79833

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1814 E. Monument ave

CITY OF BALTIMORE: (No. 1814 ST., E. Monument WARD) 8

2-FULL NAME Edward F French

(a) RESIDENCE NO. 1814 E. Monument ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Mar 31, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Rud Seasonality

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Alex F. French

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisville Ky.

12 MAIDEN NAME OF MOTHER Mary Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Alex F. French (Address) 1814 E. Monument ave

15 Filed. 19 Registrar

OCT 11 1923

ROBERT P. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/23 19

17 I HEREBY CERTIFY, That I attended deceased from 10/7/23, 19 ..., to 10/10/23. 19 ..., that I last saw ~~him~~ alive on 10/9/23. 19 ..., and that death occurred, on the date stated above, at 2 10 p. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) T. H. Wiser M. D.

10/10/23. (Address) 130 N Loudon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 13, 1923

20 UNDERTAKER Wm Lee — ADDRESS 507 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ALL ITEMS must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 79834

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 03
145-D 79834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital
CITY OF BALTIMORE: (NO. ST., 16 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Hefner

(a) RESIDENCE NO. 2318 Riggs Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Hefner

6 DATE OF BIRTH (month, day, and year) Sept 20, 1898

7 AGE: Years 25 Months 1 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Lloyd Ewing
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Mary Jennings
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Howard Ewing
(Address) 1833 Brunt St

Filed OCT 11 1923, 19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1923, to Oct. 9, 1923, that I last saw her alive on Oct. 9, 1923, and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:
Inversion of Uterus following delivery on Oct. 3-1923.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operative Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 9-1923
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) R. J. [illegible], M. D.
, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral
DATE OF BURIAL: Oct 11 1923

20 UNDERTAKER: Wm. Cook
ADDRESS: 502 E. North Av.

...Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 79835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital N. Calvert 78 ST. WARD)

REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine L. Thompson

(Residence in Baltimore: No. 1110 E. Frederick Road Emergency Institution ST.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Divorced

6-DATE OF BIRTH, May 17 1878

(Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. not any
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Wash. Co. Md.

PARENTS.

10-NAME OF FATHER, Elias Rowland

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catherine Krotzer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry E. Baker

(Address) Hagerstown Md.

15- Filed OCT 11 1923, 191... ROBERT H. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1923

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

Suicide

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) [illegible] Blades M. D.

(Coroner)

Oct. 10 1923 (Address) 143 E. Lenox

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hagerstown Md. DATE OF BURIAL, Oct 11 1923

20-UNDERTAKER John Whitehill ADDRESS 1201 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79836

CERTIFICATE OF DEATH.

D 79836

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Market st ST. Mt Winans WARD 25)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Carll

(a) RESIDENCE. No. 2203 Market st McKinnon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Carll

6 DATE OF BIRTH (month, day, and year) Dec 15 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm H. Carll
(Address) 1119 Edmondson st

15 Filed OCT 11 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 11, 1923, that I last saw her alive on Oct 10, 1923, and that death occurred, on the date stated above, at 12.40 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Hall, M. D.

, 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 13 19 23
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state full of information

Spec.—1-10-21—M&T—1500 Bks.

D 79837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79837

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2404 Callow St., 13 WARD)

2-FULL NAME Sidney Paul Spear Jr.

(a) RESIDENCE NO. 2404 Callow Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16 1923

7 AGE — Years — Months — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Sidney P. Spear

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Madanick

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Sidney Spear (Address) 2404 Callow Ave

15 Filed OCT 11 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 29 Septemb, 1923, to 10 Octob, 1923, that I last saw h alive on 10 Octob, 1923, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Enteritis, acute

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gilbert W. Rosenthal M.D.

19 (Address) 2446 Lakeview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 10/11/ 1923

20 UNDERTAKER: David Sondheim

ADDRESS: 119-21 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79838

CERTIFICATE OF DEATH.

100-001

D 79838

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2817 Alameda av (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frederick Hemmeter

(a) RESIDENCE. (No.) 2817 Alameda (St.,) 9 (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Becks Hemmeter

6 DATE OF BIRTH (month, day, and year): 1856, 4-3

7 AGE: Years 67; Months 6; Days 6; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Actor, Mobile Lyffe

(b) General nature of industry, business, or establishment in which employed (or employer): F Hemmeter Est

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Louis Brandt 2817 Alameda.

15 Filed ... , 19 ... Registrar

OCT 1 1923

ROBERT R. BRAUNLICH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1921, to Oct 9, 1923.

That I last saw him alive on Oct 9, 1923.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

(Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel

DATE OF BURIAL: 10/12 1923

20 UNDERTAKER: J. Few McCully

ADDRESS: 130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Age should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79839

CERTIFICATE OF DEATH.

185 ✓ D 79839

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 W. Lanvale ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Edwin Cox

(a) RESIDENCE. NO. 306 W. Lanvale St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (~~WIFE~~) of Mary Etta Cox

6 DATE OF BIRTH (month, day, and year) Sept 19 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER James H. Cox

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Davey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant (Address) George H. Cox 17 W. Biddle St

15 Filed OCT 11 1923 Robert P. Bartlett Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 5, 1923, to Oct 10, 1923, that I last saw h in alive on Oct 10, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Ruptured urethra - prostate
Ruptured bladder (over)

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Accidental Fall

(duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Clinical

(Signed) George H. Cox, M. D.

, 19 (Address) 17 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 12 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fort Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

J. T. Hennessy
10/11/23 Coroner N. Y. Co.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pt. was a very old man & has had several falls - last on Oct 5; 1923 + has been gradually sinking ever since. Catheterized daily. Ruptured urethra developed. Given one clysma enema 10-9-23 by V.N.A. nurse. Vomited dark blood 10-10-23 and died almost instantly. No evidence of fractured bones. Probably ruptured internal

Spec.—1-10-21—M&T—1500 Bks.

D 79840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Fleet ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Telakowicz.

(a) RESIDENCE No. 2112 Fleet ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 13 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Helen Telakowicz

6 DATE OF BIRTH (month, day, and year) Sept 8-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ludwick Telakowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Walenski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen Telakowicz. (Address) 2112 Fleet

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to Oct 8, 1923.

that I last saw him alive on Oct 7, 1923,

and that death occurred, on the date stated above, at 6.00 a.m.

The CAUSE OF DEATH* was as follows:

Intra-cranial Tumor

(duration) yrs. ½ mos. ... ds.

CONTRIBUTORY (Secondary) Intra-cranial tumor

(duration) yrs. 8 mos. 9 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edward L Johnson, M. D.

10/10, 1923 (Address) 1212 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 12 1923
UNDERTAKER	ADDRESS
Wm Fialkowski	1618 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 11 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79841

D 79841

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Sixth St ST., H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Harvey

(a) RESIDENCE NO. 1219 Sixth St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Harvey

6 DATE OF BIRTH (month, day, and year) July 3rd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Frazier Fuzzard

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Hardman

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Howard Harvey
(Address) 1219 Sixth St

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1923

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to Oct 10, 1923,

that I last saw h alive on Oct 9, 1923,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Glanders

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/10, 1923 (Address) 317 Exeter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bur. Christ Ch

DATE OF BURIAL: 12 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 11923

Robert P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79842 ✓ D 79842

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 Williamson ST., 23 WARD)

2-FULL NAME Virginia Sykes

(a) RESIDENCE NO. 9 Williamson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should be careful to state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Mulatto

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of John W Sykes

6 DATE OF BIRTH (month, day, and year) Aug 17 - 1828

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	95	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge Md
(State or country)

PARENTS

10 NAME OF FATHER James Cannon

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Cannon

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Laura Sykes.
(Address) 9 Williamson St

15 Filed ..... 19 ..... Robert L. Harrison, Registrar

1 1923 ~~Deputy Health Officer~~ Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Oct 11, 1923, that I last saw her alive on Oct 8, 1923, and that death occurred, on the date stated above, at 305 a m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardio vascular renal disease (duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted —
If not at place of death? ...

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Mc Cluskey, M. D.

10/11, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Oct-13-1923

20 UNDERTAKER Williams Cook — ADDRESS 502 E Nash

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79843

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home - Chestnut Hill Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elizabeth Phillips.

(a) RESIDENCE. No. St. Elizabeth's Home - Chestnut Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negress

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 20/22

7 AGE — Years: 1 — Months: 1 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Florence Emily Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed OCT 11 1923, 19 Robert F. Harrison, Registrar

Assistant Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 1923

17 I HEREBY CERTIFY, That I attended deceased from September, 1923, to October 9, 1923, that I last saw her alive on October 9, 1923, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis J. Ayd, M. D.

Oct 9, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: OCT 11 1923, 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

Wm. R. WOODALL.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

OCT 11 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79844

CERTIFICATE OF DEATH.

118 D 79844

1-PLACE OF DEATH Hebrew Hospital.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument St & Rutland Ave ST., 8 WARD)

2-FULL NAME Katherine Ruzicka.

(a) RESIDENCE NO. 1300 Luzerne St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Ruzicka

6 DATE OF BIRTH (month, day, and year): September 1873

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Vojtech Konadal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Anna Matejka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: John Ruzicka

(Address) 1300 Luzerne Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1923

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1923, to October 9, 1923, that I last saw her alive on October 9, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation and failure.

(duration) yrs. mos 3 days.

CONTRIBUTORY (Secondary) Intestinal obstruction

following ~~appendectomy~~ (duration) yrs. ~~mos~~ mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? yes. Date of 10/6/23

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Nathan Friedheimer M. D.

10/9, 1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Oct 12 1923

20 UNDERTAKER: Frank Crabbe

ADDRESS: 916 Eastlake

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 11 1923

Spec.—1-10-21—M&T—1500 Bks.

D 79845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 79845

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette E Gaye ST., 9 WARD)

2-FULL NAME Anna Agnes A. Sheehan-Thompson

(a) RESIDENCE NO. 1925 E. 30th ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Timothy Sheehan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Hospt Record
(Address)

15 Filed ....., 19 Robert P. Harrison, Registrar

T 11923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16th, 1923, to Oct. 10th, 1923, that I last saw her alive on Oct. 10th, 1923, and that death occurred, on the date stated above, at 10½ A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thompson, M. D.

10/15, 1923 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Cem | DATE OF BURIAL 10/12/23

20 UNDERTAKER Geo. Tinley Fulton | ADDRESS Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79846 — 90 — D 79846

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3152 Wilkens Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Francis Davidson

(Residence in Baltimore: No. 3152 Wilkens Ave St.; 4 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) August (Day) 8, (Year) 1856.

7-AGE, 67 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER, John Hoover

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER ~~Mary~~ Mary Overholtzer

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Married W. Davidson

(Address) 3152 Wilkens Ave

15-

OCT 12 1923

Filed ..... 191.....

ROBERT R. KRAUTER.
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) 10 (Day) 10, (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1923, to Oct 10 1923, that I saw her alive on Oct 10 1923 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration 10 yrs
Contributory Chronic Interstitial Nephritis
Acute Bronchopneumonia Complication
(Duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) yrs. mos. 4 ds.

(Signed) Thomas M. Hagner M. D.

Oct 10, 1923 (Address) 3316 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. ..... ds. In the State 5 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 3152 Wilkens Ave

Former or usual residence Fairfield Pennsylvania

19-PLACE OF BURIAL OR REMOVAL, FAIRFIELD PA

DATE OF BURIAL. OCT 13, 1923

20-UNDERTAKER ROBERT BROOKS SON

ADDRESS COR. CALHOUN & COLLINS

S.T.

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79847

D 79847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 East ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Barnes

(a) RESIDENCE NO. 523 East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elijah Barnes

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Louisa Co. Va.

PARENTS

10 NAME OF FATHER: Thornton Mallory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Clayton Carter

(Address) 708 N. Eutaw St

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk. ID Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1923, to Oct. 9, 1923, that I last saw her alive on Oct. 4, 1923, and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of rt. ear + Hemorrhage from the ear

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Abscess of ear

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

(Address) 1506 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery DATE OF BURIAL: Oct 12. 1923

20 UNDERTAKER: Wm. R. C. Elliott ADDRESS: 17 E. Eastland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 79848

CERTIFICATE OF DEATH

14006 79848

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 244 W Hoffman ST. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Franz

(Residence in Baltimore: No. 244 W Hoffman St.: 69 yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan 31, 1854 (Month) (Day) (Year)

7 AGE: 69 yrs. 8 mos. 10 ds. If LESS than 1 day ..... hrs. or ..... mins.? X

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9 BIRTHPLACE (State or country): Prussia = Germany

PARENTS

10 NAME OF FATHER: George Franz

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Schneider

13 BIRTHPLACE OF MOTHER (State or country): Rukumm

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Ferdinand Franz

(Address) 244 W. Hoffman St

15.

Filed OCT 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 11, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923. to. Oct 11 1923.

that I saw him alive on Oct 10, 1923.

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 1/4 ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) 5 yrs. X mos. X ds.

(Signed) Lewis W Eastman Jr M. D.

Oct 11, 1923 (Address) 1505 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/15 ,1923

20 UNDERTAKER: Louis E Jonson — ADDRESS: 1231 Brunswick St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dr L Curtis Street
711 Park Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79849

CERTIFICATE OF DEATH.

90 D 79849

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Park Ave. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy J. Williams.

(a) RESIDENCE NO. 1607 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of, (or) WIFE of John F. Williams

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER Thos. Sanderson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Raymond S. Williams

(Address) 7 E. Biddle St.

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19 19 to Oct 10 19 23.

that I last saw h[illegible] alive on Oct 10th 19 23.

and that death occurred, on the date stated above, at 10:40 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) many yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical —

(Signed) L. C. Street, M. D.

19 (Address) 712 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Oct 12, 19 23

20 UNDERTAKER: John C. Mitchell, 1201 W. Fayette st — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 79850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79850

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 N. Calvert ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Crump Brown.

(a) RESIDENCE NO. 1633 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R. Brown.

6 DATE OF BIRTH (month, day, and year): 4/23/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): --------

(c) Name of employer: --------

9 BIRTHPLACE (city or town) (State or country): England B.I.

PARENTS

10 NAME OF FATHER: Thos. W. Crump.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Margaret Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Jas. A. Brown 1633 N. Calvert St.

15 Filed OCT 12 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 10, '23

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to Oct 10th, 1923, that I last saw her alive on Oct. 10th, 1923, and that death occurred, on the date stated above, at 4:20 p m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) 5 Hours

CONTRIBUTORY (Secondary) ARTERIO-SCLEROSIS

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Sheaer M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 13 1923

20 UNDERTAKER: Jno. O. Mitchell, ADDRESS 1201 W. Fayette st.

Spec.—I 10-21—M&T—1500 Bks.

D 79851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79851

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home St., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Selenkow

(a) RESIDENCE NO. 111 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
80	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Selenkow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida London

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Rebecca Felsteyn 209 S Caroline St

15 Filed . . 19 . . Registrar

OCT 12 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 11, 1923, that I last saw h[illegible] alive on Oct 11, 1923, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic

(duration) yrs. 7 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno J Bayne M. D.

10/12 1923 (Address) 210 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Hebrew Cem.

DATE OF BURIAL Oct 12 1923

20 UNDERTAKER S Levinson & Bro

ADDRESS 112 7E Bullo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79852

CERTIFICATE OF DEATH.

101-001 ✓

D 79852

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1328 Hanover St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F Powell

(a) RESIDENCE. NO. 1328 Hanover ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21st 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) OW

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Robert Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Henrietta Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Florence Kohrna

(Address) 1912 Hillcrook Ave

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1923, to October 10, 1923

that I last saw him alive on October 10, 1923,

and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Carrick, M. D.

10/11 1923 (Address) 412 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Oct. 12. 1923

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1722 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79853 — 38 — D 79853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Gibson

(a) Residence No. 925 Woodyear St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 1890

6-DATE OF BIRTH (month, day and year)

7-AGE, 33 yrs. mos. dls.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. 286

(b) General nature of industry, business, or establishment in which employed (or employer). Expressman

(c) Name of employer.

9-BIRTHPLACE (city or town). Va.
(State or Country),

PARENTS.

10-NAME OF FATHER, Lemuel Gibson

11-BIRTHPLACE OF FATHER (city or town). Va
(State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Davis.

13-BIRTHPLACE OF MOTHER (city or town). Va
(State or Country),

14- (Informant). Hospital Records

(Address).

15- Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/16/23

17- I HEREBY CERTIFY, That I attended deceased from 8/28/23, 19.., to 10/11/23, 19.., that I last saw h[illegible] alive on 10/16/23, 19.., and that death occurred, on the date stated above, at 6.55 a. m.

The CAUSE OF DEATH* was as follows:

Lues Aortic Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Cardiac failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? 9

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) H. W. Kelly M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL, 12th Oct 19 23

20-UNDERTAKER. John W Evans — ADDRESS 1400 Madison

Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Osmond Sommerville

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79854

CERTIFICATE OF DEATH.

24-001 D 79854

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 10 WARD)

2-FULL NAME Osmond Sommerville

(a) RESIDENCE NO. 1122 Eaton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Victoria Sommerville

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE: Years 68 Months Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1923 to Oct 11, 1923

that I last saw h[e] alive on Oct 10, 1923

and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bay Chronic endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith M. D.

10/11/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Oct. 13 1923

20 UNDERTAKER: J. C. Wadefield — ADDRESS: 914 Druid Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 79855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 179

CITY OF BALTIMORE (No.) Mercy Hospital St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Slaga

(Residence in Baltimore: No. 535 S Rose St

St.; // yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Not known, 1 (Month) (Day) (Year)

7-AGE: 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Andrew Slaga

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Katie Bigos

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Stachura

(Address) 731 S Luzerne

15-

Filed OCT 12 1923, 191.. ROBERT M. KRAUTER, Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct 10, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident (Fall)

Burns to Val

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Condon Blades M. D.
(Coroner)

Oct 12, 23 (Address) 1431 N Leray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Oct 13, 1923

20-UNDERTAKER: Stephen J Fialkowski

ADDRESS: 1000 S Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state fully and correctly all items applicable.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79856

CERTIFICATE OF DEATH.

129 D 79856

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1033 Homewood Ave. ST., 10 WARD)

2-FULL NAME John C. Schmidt

(a) RESIDENCE NO 1033 Homewood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Schmidt

6 DATE OF BIRTH (month, day, and year) May 3/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 140
(c) Name of employer Hotel Belvedere

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Mrs. Lena Schmidt
(Address) 1033 Homewood Ave.

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(ied in coma)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cotton, M. D. (Coroner.)

10/11/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 13 192 3
20. UNDERTAKER Uhlmann Coote	ADDRESS 502 E North Ave

Exact statement of OCCUPATION. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79857

CERTIFICATE OF DEATH.

D 79857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1817 Bolton St. St., 14 WARD)

2-FULL NAME Eliza Snellenberg

(a) RESIDENCE NO. 1817 Bolton St. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Snellenberg

6 DATE OF BIRTH (month, day, and year): April 25 1842

7 AGE — Years: 81 Months: 5 Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jacob Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Lopeces

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis Snellenberg (Address) 1817 Bolton St.

15 Filed OCT 12 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/10/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 10, 1923, that I last saw h[illegible] alive on Oct 10, 1923, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Cerebral Sclerosis Myocardial degeneration

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & Renal examination

(Signed) Louis H. Schultz M. D.

, 19 (Address) #17 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem. DATE OF BURIAL: 10/14/ 1923.

20 UNDERTAKER: David Sondheim ADDRESS: 118 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

May Adams ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79858

D 79858

CERTIFICATE OF DEATH.

Registered No. 16 49

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Adams

(a) Residence No. 1013 Lutelock St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Adams

6-DATE OF BIRTH (month, day and year) Sept 6, 1851

7-AGE. 72 yrs. 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Bookkeeper

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Charles Thornton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Records,

(Address) Fresh Hospital

15-

Filed OCT 12 1923, 193 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/6/23

17- I HEREBY CERTIFY, That I attended deceased from 10/6/23 19 to 10/6/23 19

that I last saw her alive on 10/4/23 19

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Other Intestinal Complications

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) K. W. Dolley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. 10/13 19 23

20-UNDERTAKER. Chas P. Evans & Son ADDRESS 18 W. Mt. Royal Ave

Instructions on back of certificates.

Name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See

Also, if death occurred from violence, state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

Priscilla Gray

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79859

CERTIFICATE OF DEATH.

91-002

D 79859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 210 S. Ct. Ave ST., 14 WARD)

2-FULL NAME Priscilla Gray

(a) RESIDENCE NO. 210 S. Ct. Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Jno Gray

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Hommon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Peter Hommon

(Address) 210 S. Ct. Ave.

15 Filed OCT 1 1923, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from 1920 to Oct 10th 1923.

that I last saw her alive on Oct 9th 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Influenza & old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) A. Lee Ehrich, M. D.

, 19 23 (Address) 924 Mon. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon

DATE OF BURIAL Oct 12 1923

20 UNDERTAKER Samuel Hemsley

ADDRESS W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stanislaus Zielinski

D 79860 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 79860

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Lancaster ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Zielinski

(a) RESIDENCE NO. 1711 Lancaster ST. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Franziszek Zielinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Aniela Iwicki

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Frank K Zielinski
(Address) 1711 Lancaster

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1923

17 I HEREBY CERTIFY, That I attended deceased from October 5, 1923, to October 8, 1923, that I last saw h✓ alive on October 8, 1923 and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

marasmus

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) indigestion

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Delaware

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Swarbrick Jr., M. D.

10. 11. 1923 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	10/12 1923
UNDERTAKER William Jackson	ADDRESS 1618 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Lois B. T. Hartman

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79861

CERTIFICATE OF DEATH.

12 3 ✓ D 79861

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 17 WARD)

2-FULL NAME Mrs. Rowland F. Hartman (Lois) Lois B. Tregellas Hartman

(a) RESIDENCE No. 2428 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Rowland F. Hartman

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	52 Years	0 Months	29 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Joseph Tregelles

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Mary Rogers

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Rowland F. Hartman (Address) 2428 Maryland Ave.

15 Filed OCT 12 1923 Registrar ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1923, to Oct 12, 1923, that I last saw her alive on Oct 12, 1923, and that death occurred, on the date stated above, at 2 10 Am.

The CAUSE OF DEATH* was as follows:

Surgical Shock following Cholecystectomy and Cysticocholedocotomy

(duration) — yrs. — mos. 1/2 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 11, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R.B. Price M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Mt. Olivet Cemetery, Md. DATE OF BURIAL 10/15 1923

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79862

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Zerhusen

(a) RESIDENCE NO. 1228 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? 72 yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of ~~the~~ the Late or) WIFE of Henry Zerhusen

6 DATE OF BIRTH (month, day, and year) June 19 1850

7 AGE: Years 73 | Months 3 | Days 22 | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Mathias Streb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Antoinette Tragesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss. Catherine Zerhusen

(Address) 1228 E Eager St

15 Filed OCT 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 11, 1923,

that I last saw h[illegible] alive on Oct 11 - 1.30 P.M. 19

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? All

(Signed) W. J. Riley, M. D.

1923 (Address) 1134 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct. 15 1923

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79863

CERTIFICATE OF DEATH.

90 D 79863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chapel Gate Lane Ten Hills ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Knabe

(a) RESIDENCE NO. Chapel Gate Lane Ten Hills ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, ~~or Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Knabe

6 DATE OF BIRTH (month, day, and year): June 18th, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: ------ Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Katie Knabe

(Address) Chapel Gate Lane Ten Hills

15 Filed OCT 12 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10th, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1923, to Oct. 10, 1923, that I last saw her alive on Oct. 10, 1923, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

2.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pessagno M. D.

10.11.23. , 19 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 13th, 1923

20 UNDERTAKER: J. Ritchie Love — ADDRESS: 1723½ Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79864

D 79864

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 McHenry ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Rehling

(a) RESIDENCE NO. 1806 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood floor layer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Butte Mont.
(State or country)

PARENTS

10 NAME OF FATHER Henry Rehling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Rethman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Henry Rehling
(Address) 1806 McHenry St

15 Filed OCT 12 1923 Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1922, to Oct 11, 1923, that I last saw him alive on Oct 11, 1923, and that death occurred, on the date stated above, at 12-30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Over 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. O'Hare M. D.

10/11/23 (Address) 1202 Huntingdon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL Oct 13 1923

20 UNDERTAKER Harry H. Wetzler ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 79865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 79865

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 Lamont ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Schaefer Jr

(a) RESIDENCE NO. 1334 Lamont ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cecilia Dombrowsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Cecilia Dombrowsky
(Address) 1334 Lamont St

15 Filed OCT 12 1923 Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/11/23, 19..., to 10/12/23, 1923, that I last saw h... alive on 10/12/23, 19..., and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maynard Davis, M. D.

, 19 (Address) 1 W Mt Royal Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 13 1923

20 UNDERTAKER Harry A. Witz & Co ADDRESS 1531 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 79866

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 E Lanvale ST., 17 WARD)

2-FULL NAME Josephine Rogers Cooke

(a) RESIDENCE No 209 E Lanvale ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Daniel Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER Eliza Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs George E Prine
(Address) 1104 Eutaw Pl

15 Filed ..., 19 ..... Registrar

131923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1923, to Oct 11, 1923,

that I last saw her alive on Oct 11, 1923,

and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) Unknown ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Examination Sputum Exam

(Signed) W R Rogers, M. D.

, 19 (Address) 243 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md

DATE OF BURIAL: Oct 13 1923

20 UNDERTAKER: Henry W Jenkins & Son Co

ADDRESS: Richmond Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79867 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79867

CERTIFICATE OF DEATH. 118-003

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Inf. ST. 22 WARD)

2-FULL NAME Louis A. Bethke

(a) RESIDENCE NO. 309 S. Wolfe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or WIFE of): Elizabeth Bethke

6 DATE OF BIRTH (month, day, and year): 7-5-1851

7 AGE: Years 72 Months 3 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer): Friendly Inn. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Cyrus H. Coe. Broadway Inn.

15 Filed 1 3 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-10 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1923, to 10-10, 1923, that I last saw him alive on 10-10, 1923, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 309 S. Wolfe St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Cayetano Paulucci, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 10/17/23

20 UNDERTAKER: H. E. Hughes — ADDRESS: 1111 E. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79868

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Longwood ST., 16 WARD)

2-FULL NAME Patrick O. Lewis

(a) RESIDENCE No. 1128 Longwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should write.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 14, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER O'Neill Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. Wehr

(Address) Forest Park

15 Filed ..... , 19 .....

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July , 1920 , to October 12 1923.

that I last saw h alive on October 18 , 1923 ,

and that death occurred, on the date stated above, at 12.25 a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Int Nephritis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Irvin S. Harper , M. D.

10/12 1923 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Oct. 15 19

20 UNDERTAKER H. E. Hughes

ADDRESS 804 N. Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 79869

CERTIFICATE OF DEATH.

109-002 79869

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 N Edew. St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Jones

(Residence in Baltimore: No. 308 N. Edew St.; 14 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	C	Single

6-DATE OF BIRTH, April (Month) 17 (Day), 1909 (Year)

7-AGE, 14 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Russell J. Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Rachel Butler

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. J. Jones (Father)

(Address) 308 N Eden St

15-

Filed 131923, 19.., Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1923, to Oct 10 1923, that I saw h[er] alive on Oct 10 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pericarditis & Mitral Regurgitation

(Duration) yrs. mos. 3 wks ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 8 ds.

(Signed) R. J. Young M. D.

10/11, 1923 (Address) 1420 Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Asbury Cemetery	Oct 13th, 1923
20-UNDERTAKER	**ADDRESS**
Milton Davis	315 W Eden St

Important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79870 D 79870

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 5th av ST 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sidney Ford

(a) RESIDENCE. No. 702 5th Ave Rogual Ster WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (WIFE of) Sarah R. Ford

6 DATE OF BIRTH (month, day, and year) June 19-851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72	72	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 29

(c) Name of employer C & P Telephone Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Child daughter (Address) 702 5th av

15 Filed 31923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Oct 10th, 1923, that I last saw him alive on Oct 10th 1923, and that death occurred, on the date stated above, at 5 am m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Coma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. A McClenny, M. D.

10/11, 1923 (Address) 400 N. Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 13 1923

20 UNDERTAKER Josiah Segar ADDRESS 1600 N North Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79871

D 79871

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Otterbein ST., 21 WARD)

2-FULL NAME Charles Cornish

(a) RESIDENCE NO. 327 Otterbein ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Cornish

6 DATE OF BIRTH (month, day, and year): Aug, 22, 1888

7 AGE — Years: 35 — Months: 1 — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Scour

(b) General nature of industry, business, or establishment in which employed (or employer): Clean Clothes

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: William Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Maryland.

12 MAIDEN NAME OF MOTHER: Eliza Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland.

14 Informant: Sarah Cornish
(Address): 327 Otterbein St

15 Filed ..... 1923, 19 ..... Registrar
Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct, 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 28, 1923, to Oct, 11, 1923.

that I last saw him alive on Oct, 10, 1923,

and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum exg - 3 ex -

(Signed) David Fradkin M. D.

10/11 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct 14 1923

20 UNDERTAKER: John H. Fradkin — ADDRESS 142 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79872 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79872

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 607 S Sharp St ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidonia Gaut

(a) RESIDENCE NO. 607 S Sharp ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. R Gaut

6 DATE OF BIRTH (month, day, and year): Sept 1897

7 AGE — Years: 21 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Sam Hollis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Fannie Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Fannie Hollis 607 S Sharp St

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/10/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from 10/4/ 19 23 to 10/10/ 19 23

that I last saw her alive on 10/10/ 19 23

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Ten days (duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Recurrent Bronchitis (duration) ten days yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopical clinical

(Signed) J. Emory Bowley, M. D.

10/11/ 19 23 (Address) 908 E Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md. Auburn — DATE OF BURIAL: Oct 14 19 23

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Lexington St

Robert F. Harrison
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79873

161-0010

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Hoffman ST., 11 WARD)

2-FULL NAME Richard Evans

(a) RESIDENCE NO. 413 N. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/10/23

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) W

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John H Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Lucille Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Lucille Evans

15 Filed Oct 31 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct. 12, 1923,

that I last saw h alive on Oct. 11, 1923

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

, 19 (Address) 1041 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS: 142 Until St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 7987+ D 7987+

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital St., 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Goldstein

(a) RESIDENCE NO. 522 S Smallwood st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 10/10/23

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Sarah Gruberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Harry Goldstein

(Address) 522 S Smallwood st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 12, 1923, that I last saw him alive on Oct 12, 1923, and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Status lymphaticus

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Alexander Novey M. D.

10/12 1923 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: 10/13 1923

20 UNDERTAKER: A Lurser & Bro

ADDRESS 127 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital St., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Juhn.

(a) RESIDENCE NO. 3231 N. Fremont ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeping

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Aaron Juhn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Savana

12 MAIDEN NAME OF MOTHER: Hannah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Savana

14 Informant (Address): Otto Mehlinger 2100 Brookfield

15 Filed OCT 23 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1923, to Oct 12, 1923, that I last saw her alive on Oct 12th, 1923, and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (lower and middle lobes of lung)

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis - Senility

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidore S. Frey, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cemetery — DATE OF BURIAL: 10/14 1923

20 UNDERTAKER: J. Abrams Co — ADDRESS: 164 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79876 D 79876

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 2640 Bernard ST.: 17 WARD)

2-FULL NAME Clarence Proctor

(a) RESIDENCE. No. 2640 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred The yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Normant R Proctor

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hoover

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Norman R Proctor
(Address) 2640 Bernard St

15 Filed ..... 19 ..... Registrar,

CF 31923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Oct 12, 1923, that I last saw h.. alive on Oct 12, 1923, and that death occurred, on the date stated above, at 920A m.

The CAUSE OF DEATH* was as follows:

Entero colitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) C. J. Norment M. D.

10 12 1923 (Address) 3847 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 13 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

Burial Permit Clerk

TION is v... important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79877

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 S Kenwood ave ST., 1st WARD)

2-FULL NAME Magnus A Vogelgesang

(a) RESIDENCE NO. 636 S Kenwood ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Conrad Vogelgesang

6 DATE OF BIRTH (month, day, and year) July 13 1849

7 AGE Years 74 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Ott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Fischer
(Address) 636 S. Kenwood ave.

15 Filed ..... 19 ..... Registrar

131923

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to Oct 10, 1923, that I last saw h[illegible] alive on Oct 10, 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall bladder + Liver

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + Surgical findings

(Signed) Dr Swope, M. D.

....., 19 ..... (Address) 301 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 13 1923

20 UNDERTAKER Robt Schnorr Sons — ADDRESS W. Balto

PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79878

CERTIFICATE OF DEATH.

90 D 79878

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Fulton Ave. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Yealdhall

(a) RESIDENCE NO. 103 N. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malhor Yealdhall

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) (W)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edw. Meeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Judy Lee Ann Trevolian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. C. Bradley.

(Address) 103 N. Fulton Ave.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

1 131923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, ..., 1923 ....., to October 11, 1923.

that I last saw her alive on October 10, 1923.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

Cardiac hypertrophy.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Hawkins M. Dr.

10/11 23 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 10/13 1923

20 UNDERTAKER Fox & Turley

ADDRESS Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

Cor.—1-12-23—M&T—100 Blks.

D 79879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79879

165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Weist

(a) RESIDENCE No 3604 Eastern Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred M. Weist

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 25	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 137
(c) Name of employer Husband

9 BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10 NAME OF FATHER Mr Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Arkansas

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Arkansas

14 Informant Fred M. Weist
(Address) 3604 Eastern Ave

15 Filed ..... 192 .....

Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B Torsey M. D.
(Coroner)

Oct 12 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem.

DATE OF BURIAL Oct 13 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

See instructions on back of certificate. Exact statement of OCCUPATION.

Spec.—1-30-21—M&T—1800 Blks.

D 79880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79880

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1518 Druid Hill St. 14 WARD)

2-FULL NAME Dorothy Elizabeth Watkins

(a) RESIDENCE NO. 1518 Druid Hill Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	1	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Leonard Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co. Md

14 Informant Leonard Watkins
(Address) 1518 Druid Hill Ave.

15 Filed ..... 19 .....
Registrar

CT 13 1923

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 11, 1923, that I last saw her alive on Oct 11, 1923, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

10/12 1923 (Address) 1928 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park [illegible] Ceme. Md

DATE OF BURIAL 10/14 1923

20 UNDERTAKER James H. Lewis

ADDRESS 313 Pine Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY ... state

Spec.—1-10-21—M&T—1500 Blks.

D 79881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79881

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 512 E. 28th. (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wm Wild

(a) RESIDENCE NO. 512 E. 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha M. Wild

6 DATE OF BIRTH (month, day, and year): Sept 9 1842

7 AGE — Years: 81 — Months: 1 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Malaga NJ

PARENTS

10 NAME OF FATHER: Geo. Wild

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Fred'k W. Wild Jr. Chicago Ill

15 Filed Oct 13 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1923 to Oct 11 1923, that I last saw him alive on Oct 11 1923, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Chronic Nephritis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Stella Hemming, M. D.

Oct 12, 1923 (Address) 2000 Hoffman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: Wm. Fleckenstein Sons — ADDRESS: North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

31323

Deputy Permit Clerk

Spec—12-23-21—E.B.P.S.—400 Bks.

D 79882

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

74 D 79882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2 Prospect Circle St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anderson Jackson Woodson

(a) Residence No. 2 Prospect Cir. St., Windsor Hills Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Jan 15, 1837

7-AGE 86 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Richmond (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph Woodson

11-BIRTHPLACE OF FATHER (city or town) Richmond (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Julia Edwards

13-BIRTHPLACE OF MOTHER (city or town) Richmond (State or Country), Virginia

14- (Informant) Emmett Woodson

(Address) 2 Prospect Circle

15- Filed ..... 192 ..... Registrar.

OCT 13 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Oct 8 1923

that I last saw him alive on Oct. 8 1923

and that death occurred, on the date stated above, at 10 hr 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. S. Schmeisser, M. D

, 19 (Address) 3101 Clifton Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lincoln Cemetery	Oct 15 1923
20-UNDERTAKER, George J. Smith	ADDRESS 1532 Hollins

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks. 79883

D 79883 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79883

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Irving Krob

(a) RESIDENCE No. Westminster Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Myrtle Krob

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 44 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER John Krob

11 BIRTHPLACE OF FATHER (city or town) Wmsboro Md (State or country)

12 MAIDEN NAME OF MOTHER Katherine Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant University Hosp (Address)

15 Filed OCT 14 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-2 .1923. to 10-13 .1923 that I last saw him alive on 10-13 .1923 and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

acute appendicitis (abscess)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-12-23

Was there an autopsy? yes (Partial)

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littlestown Pa — DATE OF BURIAL 10/15 1923

20 UNDERTAKER Wm J Technisons — ADDRESS North Penna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Form 1 (10M) M&T – 1500 Bks. 79884

D 79884

1644 a

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79884

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Elizabeth Davis

(a) RESIDENCE NO. 15 Admiral Blvd ST., Dundalk WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (~~Husband~~ or) WIFE of: Frank Davis

6 DATE OF BIRTH (month, day, and year): Aug. 6, 1865

7 AGE — Years: 58 — Months: 2 — Days: 7 — If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Joe Haywood

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Margaret Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: JOHNS HOPKINS HOSPITAL.

(Address) .....

15 Filed OCT 14 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13-1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 9-, 1923, to Oct 13, 1923

that I last saw her alive on Oct 13-, 1923

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach

(duration) 0 yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Shock. (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 10-13-23

Was there an autopsy? none

What test confirmed diagnosis? Operation

(Signed) Julian D Hart, M. D.

, 19 (Address) Johns Hopkins Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Farrell Pa. — DATE OF BURIAL: 10-14-23

20 UNDERTAKER: H.E.Hughes — ADDRESS: 434 N. Broadway

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 74885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 74885

90 D 79885

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

2-FULL NAME Pius Kelmorwske

(a) RESIDENCE NO. 728 W. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? 15 yrs. ~ mos. ~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Anthony Kelmorwske

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed OCT 14 1923 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 12 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1923, to 10-12, 1923, that I last saw h—m alive on 10-12, 1923 and that death occurred, on the date stated above, at 4 55 P m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis
Mitral Stenosis & Insufficiency
Aortic Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Drace, M. D.

10-12, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 15, 1923
20 UNDERTAKER	ADDRESS
John F. Gelbenecker	120 S. Eden St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79886 ✓ 79886

CERTIFICATE OF DEATH.

D 79886

1-PLACE OF DEATH

City of BALTIMORE: (No. 305 E. 25th Street St., 17 Ward) 57

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhard Ruda

(a) Residence No. 305 E 25th Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta Ruda

6-DATE OF BIRTH (month, day and year) July 9 1865

7-AGE. 58 yrs. 4 mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jos Lewis

(Address) 1439 E Baltimore St.

OCT 14 1923 By ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/14/23

17- I HEREBY CERTIFY, That I attended deceased from Jan-10 1923 to Oct 14 1923

that I last saw him alive on Oct-13 1923

and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes -

(Duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Urine Test

(Signed) C. H. Whedden M. D.

10/14/23 19 (Address) 321 E 25

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct 17 1923

20-UNDERTAKER, Jos Lewis, 1439 E Balto ADDRESS

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79887.

CERTIFICATE OF DEATH.

94-001 78887

D 79887.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 E. Lanvale ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilde Hughes

(a) RESIDENCE NO. 1405 E Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Terence Hughes

6 DATE OF BIRTH (month, day, and year) Dec 26/1856

7 AGE: Years 66 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Phila Pa.

PARENTS

10 NAME OF FATHER: John Wertz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Pa.

12 MAIDEN NAME OF MOTHER: M Wertz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Pa.

14 Informant: Terence Hughes
(Address) 1405 E Lanvale st

15 Filed OCT 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923 to Oct 11, 1923.
that I last saw her alive on Oct 11, 1923,
and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon M. D.
10/13, 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 16 1923

20 UNDERTAKER: George F. Keith — ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 79888

D 79888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Rosedale Ave (Hamilton) WARD) 27

2-FULL NAME Annie E. Abbott

(a) RESIDENCE NO 14 Rosedale Ave (Hamilton) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Milton J. Abbott

6 DATE OF BIRTH (month, day, and year): Sept 16/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Boundbrook, N.J.

PARENTS

10 NAME OF FATHER: J.Connors

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Connors

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Milton J. Abbott
(Address): 14 Rosedale Ave

15 Filed OCT 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9ct12/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gas Asphixiation- Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J S H Collier, M. D.
(Coroner.)
10/14/23, 192 (Address) 5pd E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct. 16 1923

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Hanford ave

Exact statement of OCCUPATION necessary. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 79889 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79889 ✓ 79889 44 D 79889

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 Aliceanna St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Stanislaw Golczynski

(a) Residence No. 1615 Aliceanna St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Apr. 15, 1892

7-AGE. 31 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boiler

(b) General nature of industry, business, or establishment in which employed (or employer) Sealer Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Anthony Golczynski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Rosalia Golczynski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mrs Rozalia Golczynski
(Address) 1615 Aliceanna St.

15- Filed OCT 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 12, 1923.

17- I HEREBY CERTIFY, That I attended deceased from October 11, 1923 to October 12, 1923 that I last saw h~~im~~ alive on October 11, 1923 and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Oesophagus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial Insuff

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kruger M. D.

, 19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Oct. 15 1923
20-UNDERTAKER.	ADDRESS
John A Weber	1803 Bank St

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that CAUSE OF DEATH is properly classified. Should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79890 ✓ 79890

CERTIFICATE OF DEATH.

129 D 79890

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Rosedale Terrace ST.) 70 WARD)

2-FULL NAME John Stokes Read

(a) RESIDENCE. NO. 421 Rosedale Terrace ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Virginia Read

6 DATE OF BIRTH (month, day, and year) Aug 2 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

063

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Richard Read

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Susan Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ella Virginia Read (Address) 421 Rosedale Terrace

15 Filed OCT 14 1923, 19 ROBERT R. PRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923. to Oct 12th. 1923.

that I last saw him alive on Oct 11th, 1923,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical findings

(Signed) Wm. C. Krumbhaar, M. D.

, 19 (Address) 101 S Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 15 1923
20 UNDERTAKER	ADDRESS
Chas. S. Black	742 W. North ave

TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&P (500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79891 ✓ 79891

CERTIFICATE OF DEATH.

90

D 79891

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N Calvert ST., 11 WARD)

2-FULL NAME Octavus James Norris

(a) RESIDENCE No. 1037 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of: Widower

6 DATE OF BIRTH (month, day, and year): March 24 1840

7 AGE: Years 83; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Judge ret'd

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Oakington Harford Co Md.

PARENTS

10 NAME OF FATHER: Septamus Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Cassandra Stump

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Oakington Harford Co Md

14 Informant: Miss Cassandra Lee

(Address) 1100 Eutaw Pl

15 OCT 14 1923

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct - , 1921, to Oct 12, 1923.

that I last saw him alive on Oct 12, 1923,

and that death occurred, on the date stated above, at 9, 12, m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis —

Myocarditis —

(duration) Many yrs. — mos — ds.

CONTRIBUTORY (Secondary) Paralysis —

(duration) 2 yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas W. Lamond — M. D.

Oct 13, 1923 (Address) 1327 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: Henry H Jenkins Son Co — ADDRESS: Eutaw & Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

Otcenasek. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79892

CERTIFICATE OF DEATH.

90 79892.

D 79892

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 829 N Washington St.: 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Otcenasek

(a) RESIDENCE. No. 829 N Washington St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (Anna Otcenasek)

6 DATE OF BIRTH (month, day, and year): (Bohemia)

7 AGE — Years: 78 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Otcenasek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frank Otcenasek 829 N Washington St

15 Filed OCT 14 1923, 19 — ROBERT A. KRAUTER, Registrar — Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-12 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1923 to 10-12, 1923 that I last saw him alive on 10-11, 1923 and that death occurred, on the date stated above, at 5-45 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Cardiac Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F. Fred Chrzanowski M. D.

19 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: Frank Brockson — ADDRESS: 1716 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79893

CERTIFICATE OF DEATH.

90 D 79893

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Belvidere ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Augusta E Gallena

(Residence in Baltimore: No. 509 Belvidere ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 15 (Day), 1845 (Year)

7-AGE, 78 yrs. 5 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Richard Richardson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Emiline Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Clary

(Address) 509 West Belvedere ave

15- Filed OCT 14 1923, 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 13 1923, that I saw h[illegible] alive on Oct 13, 1923, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 13, 1923 (Address) 5016 Park Heights ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Oct 16 | DATE OF BURIAL, 1923, 191...

20-UNDERTAKER Wm. Cook | ADDRESS 502 East North ave.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79894 ✓ 79894

CERTIFICATE OF DEATH.

90 D 79894

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Federal St - Eastern Ave. (ST.) 26 (WARD)

2-FULL NAME Eliza A Koontz

(a) RESIDENCE NO. Federal St E Balmr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jerge H Koontz

6 DATE OF BIRTH (month, day, and year): Jan 20 1850

7 AGE: Years 7 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm Mahrs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Susan Coffee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jerge H. Koontz Baltimore Box 287

15 Filed OCT 14 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Oct 12, 1923, that I last saw h alive on Oct 11, 1923 and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. D. Corse M. D.

Oct 12 1923 (Address) Gardenville Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md. DATE OF BURIAL: 15 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79895

CERTIFICATE OF DEATH.

D 79895

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: ~~No.~~ 1041 W Barre ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick P Reinhart

(a) RESIDENCE NO. 1041 W Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Reinhart

6 DATE OF BIRTH (month, day, and year): Feb 3 1884

7 AGE — Years: 37 Months: 8 Days: 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frdk Reinhart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rose Hammer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Katherine Reinhart

(Address): 1041 W Barre St

15 Filed OCT 14 1923 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Oct 12, 1923, that I last saw h— alive on Oct 12, 1923 and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gruenstein M. D.

Oct 13, 1923 (Address) 517 Hoen.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 10/15 1923

20 UNDERTAKER: Geo A Jacoby Sutton — ADDRESS: Forest

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

V 79896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79896 | 129 | D 79896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Goldenberg

(a) RESIDENCE NO. Esplanade Apts WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha F. Goldenberg

6 DATE OF BIRTH (month, day, and year): Dec. 8, 1849

7 AGE — Years: 73 | Months: 10 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dept. Store

(b) General nature of industry, business, or establishment in which employed (or employer): Owner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Seligman Goldenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr. Sylvan Goldenberg Esplanade Apts

15 OCT 14 1923 ROBERT K. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/13/1923

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to Oct. 13, 1923.

That I last saw him alive on Oct. 13, 1923.

and that death occurred, on the date stated above, at 2.50 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Ch. Bright's Disease, Arterio Sclerosis

About 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia, Pulmonary Oedema

about 1 week (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Mayer M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem | DATE OF BURIAL: 10/15/1923

20 UNDERTAKER: David Sondheim | ADDRESS: 1820 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

...ATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79897

CERTIFICATE OF DEATH.

31

D 79897

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Payson ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Revelle

(Residence in Baltimore: No. 1013 N. Payson St.; St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April 13, 1890
(Month) (Day) (Year)

7-AGE, 33 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Folder
(b) General nature of industry, business, or establishment in which employed (or employer): Q.C.F.

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Peter Revelle

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Elizabeth Donahue

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Thornton

(Address) 1013 N. Payson St

OCT 14 1923 ROBERT R. KRAUTER,
Filed....., 191..... Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1922, to Oct. 11 1923, that I saw h— alive on Oct 11, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis, Pulmonary Embolism

(Duration) yrs. mos. 1 ds.

(Signed) J. D. Blair M. D.

10/12/23, 191... (Address) 804 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 10/15/..., 1923

20-UNDERTAKER H. C. Brauning & Son

ADDRESS 517 N. Schroeder St

IMPORTANT: PHYSICIANS should state with exactness the CAUSE OF DEATH. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79893

CERTIFICATE OF DEATH.

D 79893
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 46 E Barney (St.) (13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hall

(a) RESIDENCE NO. 46 E. Barney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Hall

6 DATE OF BIRTH (month, day, and year) Sept. 12-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	78	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lab.

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Edward Hamilton

(Address) 46 E. Barney St

15 OCT 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923 to Oct 13. 1923

that I last saw him alive on Oct 12, 1923

and that death occurred, on the date stated above, at 2.30 P m.,

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senile Degeneration

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) C. Hall Penn, M. D.

10/13 1923 (Address) 1 E Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Oct. 15 1923

20 UNDERTAKER Geo. L. Schwab ADDRESS 2101 Fulton Ave.

NOTE—Every item of information should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 79899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79899

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Home for the Aged St.: Valley & Preston WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Wagner

(Residence in Baltimore: No. Valley & Preston St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, April 11, 1842 (Month) (Day) (Year)

7-AGE, 81 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Ferdinand Bussen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Walter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Henry Schoulden

(Address) 4220 Harford Rd

15- Filed OCT 15 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
Myocardial Failure
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(Duration) yrs. mos. ds.

(Signed) J. H. Falter M. D. (Coroner.)

10/12/23, 191... (Address) 515 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem Co. DATE OF BURIAL, 10-15, 1923

20-UNDERTAKER E. T. B. Harker ADDRESS 115 E. North Ave

GE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79900

CERTIFICATE OF DEATH.

41 D 79900

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phoebe Johnson

(a) RESIDENCE NO 621 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	blaxk	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry Sandlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Phoebe Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Heaster Chapman
(Address) 311 Princeton Pl.

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Septicemia-following infection of left thumb.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Waller, M. D.
(Coroner)
10/15/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL 10-15 1923

20 UNDERTAKER Geo. J. A. Gilton ADDRESS 1785 Druid Hill Ave

See instructions on back of certificate. Exact statement of OCCUPA- property, classified. ...should state

Spec.—1-10-21—M&T—1500 Bks.

D 79901 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 10 D 79901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arbetta Lavezza

(a) RESIDENCE NO. 147 N. Streeper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female 4 COLOR OR RACE: white 5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23-1922

7 AGE: Years 0 Months 11 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER John Lavezza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Agatha Borbis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant John Lavezza

(Address) 147 N Streeper

15 Filed OCT 15 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 14, 1923, that I last saw her alive on Oct 14, 1923, and that death occurred, on the date stated above, at 11:05A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tracheal, pharyngeal & laryngeal

(duration) — yrs. — mos 18 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct 6

Was there an autopsy? no Culture

What test confirmed diagnosis?

(Signed) B Macfarlan M. D.

10/14/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct 15 1923

20 UNDERTAKER Frank V Bipitone — ADDRESS 3907 E Balto

TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79902

D 79902

CERTIFICATE OF DEATH.

123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 27 WARD)

2-FULL NAME Wm. H. Joyner

(a) RESIDENCE NO. 110 Emil Ave ST. Lauraville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 12 1863

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Thomas Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Petty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: V. E. Hinkel

(Address): 110 Emil Ave Lauraville

15 OCT 15 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1923, to Oct. 13, 1923, that I last saw him alive on Oct 13, 1923, and that death occurred, on the date stated above, at 9 55 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Terminal pneumonia

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Biliary calculus

(duration) yrs. mos. 3 weeks

18 Where was disease contracted if not at place of death? 110 Emil Ave. Lauraville

Did an operation precede death? Yes. Date of Oct. 11, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Physical evidence-X-ray

(Signed) Geo. B. Tybout, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenslager Oct 16 1923

DATE OF BURIAL

20 UNDERTAKER: Wm. Cook & Son

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79903

CERTIFICATE OF DEATH.

90 D 79903

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3208 Elgin Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Catherine Burns

(a) RESIDENCE No. 3208 Elgin Av ST., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? 58 yrs. 3 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Edw. R. Burns

6 DATE OF BIRTH (month, day, and year): June-28-1865

7 AGE — Years: 58 — Months: 3 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 07

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John H. Demuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Sarah A. McKee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Edw. R. Burns (Husband)

(Address) 3208 Elgin Av.

15 Filed OCT 15 1923 ROBERT M. KRAUTER, Registrar

Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1923, to Oct 12th, 1923,

that I last saw her alive on Oct 12th, 1923,

and that death occurred, on the date stated above, at 1.35 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis with dilatation

Heart trouble for 25 or 30 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema

(duration) [illegible] mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. F. Hill, M. D.

19 (Address) 1208 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

NOTICE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79904

CERTIFICATE OF DEATH.

D 79904

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 4803 Brightwood Ave St.: Rut 24th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Pouder McClayton

(a) RESIDENCE. NO. 1811 Bolton St. ST., 14 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? 66 yrs. 10 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. J. McClayton

6 DATE OF BIRTH (month, day, and year) Nov 24 1856 10 Pm

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. H. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trappe Talbott Co. Md

12 MAIDEN NAME OF MOTHER Elizabeth Pouder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Maryland

14 Informant (Address) Mr. Wm. R. McClayton (son) 3208 Carlisle Ave.

15 Filed ..... 19..... Registrar

OCT 15 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1922, to Oct 13, 1923, that I last saw h.e alive on Oct. 12, 1923, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis & hypertension (duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles L. Warner, M. D.

, 19 (Address) 3704 Dorchester Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM T. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

IION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79905

CERTIFICATE OF DEATH.

90 D 79905

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 N. Streeper St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie V. Nelson

(a) Residence No. 504 N. Streeper St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6-DATE OF BIRTH (month, day and year): Nov. 8 1881

7-AGE: 31 yrs. 11 mos. 4 ds. | If LESS than 1 day, hrs. or mts.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: William D. Nelson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Margaret Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-Informant: William W. Nelson

(Address) 504 N. Streeper St.

15-Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): October 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 9 – 1923 to October 12 – 1923

that I last saw h. alive on Oct – 11 – 1923

and that death occurred, on the date stated above, at 4 10 A. M.

The CAUSE OF DEATH* was as follows: Valvular – Heart Disease –

(Duration) 1 yrs. – mos. – ds.

CONTRIBUTORY (Secondary): Pulmonary Tbc

(Duration) yrs. 1 mos. – ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) David A Bruno M. D

, 19 (Address) 125 N Gay

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery | DATE OF BURIAL: Oct 15, 1923

20-UNDERTAKER: A. Vandeveer Sons | ADDRESS: 1710 Eutaw St.

Instructions on back of certificates.

Should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79906 ✓ 23 D 79906

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Female Hosp

CITY OF BALTIMORE: (No. 112 ½ N. Mount ST. W WARD)

2-FULL NAME Mrs. Elizabeth Horley

(a) RESIDENCE NO. 1909 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) ~~married~~ widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of husband - dec'd

6 DATE OF BIRTH (month, day, and year) ? ? ?

7 AGE Years 57 Months ? Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore (?)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Mrs Anna Buckley, 1909 Eastern Ave.

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/11, 1923, to 10/13, 1923, that I last saw her alive on 10/13, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

5 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. A. Freeman, M. D.

, 19 (Address) 112 ½ N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Oct 16 1923

20 UNDERTAKER Peter Nicolaus ADDRESS 2000 Eastern Ave

NOTICE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Thompson

D 79907. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 79907.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE (No. 646 Josephine St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Thompson

(a) Residence No. 646 Josephine St. (Usual place of abode) Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fannie Thompson

6-DATE OF BIRTH (month, day and year) July 5th 64

7-AGE. 59 yrs. 3 mos. 7 ds. OR IF LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Datto Co. Ind

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Robert Thompson

(Address) 432 S. Pine Ave

15- Filed OCT 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 26, 1923, to Oct 12, 1923

that I last saw him alive on Oct 11, 1923

and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jno R Crawley M. D.

, 19 (Address) 1622 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL, Oct 14, 23

20-UNDERTAKER Saml Crawley ADDRESS N Bdle

Spec—12-23-21—E.B.R.S.—400 Blks. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSES OF DEATH should state CAUSE OF DEATH ... may be properly classified.

Gholson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79903

CERTIFICATE OF DEATH.

101-001V

D 79908

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2213 Hargrove St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Simon Gholson

(Residence in Baltimore: No. 2213 Hargrove St.; yrs. 45 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH.

..... (Month) ..... (Day) 1..... (Year)

7-AGE. 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore
(b) General nature of Industry, business, or establishment in which employed (or employer). .....

9-BIRTHPLACE. (State or Country). Va

PARENTS

10-NAME OF FATHER. Thomas Gholson

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Patsy Blackwell

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dollie Gholson

(Address) 2213 Hargrove alley

15-

Filed OCT 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry, find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct 17 1923 (Address) 1632 Eden St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Oct 15 1923

20-UNDERTAKER, Joseph a Farrell — ADDRESS, 2314 Pinkney

This is very important. See instructions on back of certificate. Causes of death must be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be

Owens

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79909 ✓ 112 D 79909

D 79909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Osbert A St. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Owens

(a) RESIDENCE NO. 827 Osbert St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife of Byrd Owens

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Fredricksburg Va

PARENTS

10 NAME OF FATHER Richard Johnson deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country) mad-

12 MAIDEN NAME OF MOTHER mother Minor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredricksburg Va

14 Informant Byrd owens (Address) 827 austin st

15 Filed OCT 15 1923 ROBERT R. KRAUTH Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion

(Duration) Ac mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) a yrs. mos. 1 ds.

(Signed) G C Wade, M. D.

(Coroner.)

Oct 13 1923 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn cem	Oct 16th 1923
20 UNDERTAKER Joseph a Farrell	ADDRESS 2319 Dundalk St

IMPORTANT. See instructions on back of certificate. PHYSICIANS should state exactly be properly classified. Exact statement of OCCUPA-

Mrs Tuston

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hemorrhage, Gangrene, Gastritis, Erysipelas, Meningitis, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyemia, Septicemia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79910 D 79910

60-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital.

CITY OF BALTIMORE: (No. ~~Monument W. Patterson Ave.~~ 13 WARD)

2-FULL NAME Miss Helen Sheiblein.

(a) RESIDENCE No. 1543 Clifton Ave, ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): [illegible] 1899

7 AGE — Years: 24 — Months: — — Days: 24 — If LESS than 1 day, hrs. or ..... min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone operator

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible] Tel & Tel Co

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: William H Sheiblein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Helen Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs Helen Sheiblein
(Address): 1543 Clifton av

15 Filed: OCT 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/12 [illegible], 1923, to 10/12, 1923,

that I last saw her alive on 10/12, 1923,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exophthalmic goitre, (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes. Date of 10/12/23

Was there an autopsy? ~~Hypostatic~~ partial

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidore L. Fry, M. D.

(Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Lombard st

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79911

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 E. Center ST., 11 WARD)

2-FULL NAME Joseph O. Ennis

(a) RESIDENCE NO. 8 E. Center ST., 11 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Eavan Ennis

6 DATE OF BIRTH (month, day, and year) Dec. 24th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baliff in Balto.

(b) General nature of industry, business, or establishment in which employed (or employer) City Courts

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Md.

PARENTS

10 NAME OF FATHER James R. Ennis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Quantico Va.

12 MAIDEN NAME OF MOTHER Sarah E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Md.

14 Informant Robert B. Ennis

(Address) 103 W. Franklin st

15 Filed OCT 15 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8th, 1923. to Oct 12th, 1923.

that I last saw him alive on Oct. 12th, 1923,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3- ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Darrow L. Farber M. D.

1923 (Address) Sparrows Point Md

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 15 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79912

HEALTH DEPARTMENT—CITY OF BALTIMORE

Pully

CERTIFICATE OF DEATH.

D 79912

129

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 917 Pierce st ST.: 18 WARD:

2-FULL NAME Mary E. Pully

(a) RESIDENCE. NO. 917 Pierce st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fredrick

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0 to

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Julia A Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm H Miller

(Address): 917 Pierce

15 Filed OCT 13 1923 19 ROBERT H. KINSLEY Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1923, to Oct 13, 1923, that I last saw her alive on Oct 12, 1923, and that death occurred, on the date stated above, at 9, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Dropsy Uremia 20 23

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Absence

(Signed) W K Reynolds, M. D.

(Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Oct 15 1923

20 UNDERTAKER: Wm H Case Son — ADDRESS: 1410 Mon

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79913

D 79913

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Walker. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Stanford.

(a) RESIDENCE NO. 1606 Walker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John H Stanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy A Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary L Scott (Address) 1614 Druid Hill Ave

15 Filed OCT 15 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-1-, 1923, to 10-12-, 1923,

that I last saw him alive on 10-11-, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Independent (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Independent (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W Kagin, M. D.

10-13 1923 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hubert Cem

DATE OF BURIAL Oct 17 1923

20 UNDERTAKER Jam Y Base & Son

ADDRESS 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79914

CERTIFICATE OF DEATH.

129 D 79914

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 W. Franklin ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Winter Weeks

(a) RESIDENCE. NO. 1417 W. Franklin ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie H. Weeks

6 DATE OF BIRTH (month, day, and year) Jan. 13-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) City Solicitor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel H. Weeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret C. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Bessie H. Weeks 1417 W Franklin St

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28th, 1923, to Oct 12th, 1923, that I last saw him alive on Oct 12th, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tests + Physical symptoms

(Signed) Charles Heck, M. D.

Oct. 13 1923 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Oct 15 1923

20 UNDERTAKER Chas. E. Franck ADDRESS 882 Madison Ave

IMPORTANT.—PHYSICIANS should state plainly and in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 79915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79915

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Caroline ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant B Andrew Marie Edel

(Residence in Baltimore: No. 817 N. Caroline St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fe	W	Single

6-DATE OF BIRTH, 10 (Month) 14 (Day), 1923 (Year)

7-AGE, ...yrs. — mos. — ds. If LESS than 1 day, 4 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andy Edel

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Marie Hopkins

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Edel

(Address) 817 N. Carolein St

15-

Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1923, to Oct 14 1923, that I saw h[er] alive on Oct 14 1923, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) A. L. Hornstein M. D.

10/14, 1923 (Address) 733 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	Oct 16, 1923
20-UNDERTAKER	**ADDRESS**
Henry Hauck & Son	1301 E Eager St

Important. See instructions on back of certificate. ...y be properly classified. Exact statement of OCCUPATION is very ...PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

Levy.

D 79915

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 79916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 556 N. Mary ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Leroy

(a) RESIDENCE NO. 556 N. Mary St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 6 ds. How long in U. S., If of foreign birth? Jamaica yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1888

7 AGE: Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of Industry, business, or establishment in which employed (or employer): Public

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Jamaica

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Jamaica

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jamaica

14 Informant: Mrs. Short (Address) 556 N. Mary St.

15 Filed OCT 15 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6th, 1923, to Oct 13th, 1923, that I last saw him alive on Oct 10th, 1923, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Private Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) A. Levy Ellis, M. D.

Oct 15, 1923 (Address) 924 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct 15 1923

UNDERTAKER: Jno. A. Soadenn — ADDRESS 142 Eastfield Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 79917.

D 79917.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E. University Parkway ST., 12 WARD)

2-FULL NAME Martin Hoengen

(a) RESIDENCE NO. 217 E. University Parkway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Hoengen

6 DATE OF BIRTH (month, day, and year) December 2, 1842

7 AGE	Years	Months	Days	if LESS than 1 day, ... hrs. or min.
	80	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Store 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Hoengen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Martin F. Rheinhardt
(Address) 107 E. 32nd. St.

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 9th, 1923, to Oct 13, 1923.

that I last saw him alive on Oct 12, 1923,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) W. W. Pearee M. D.

10-15, 1923 (Address) 5 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 15 1923
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard St

TION is very important See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 79918

D 79918

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. 15 + 129

CITY OF BALTIMORE: (No. 1612 Lorman ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Bonner

(a) RESIDENCE No. 1612 Lorman ST., ... WARD 9 Uganda

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE — Years: 43 — Months — Days — If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Robt Taylor

(Address) 1611 Lorman St

15 Filed OCT 15 1923 19 Registrar

ROBERT N. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923. to October 13. 1923.

that I last saw her alive on October 12. 1923.

and that death occurred, on the date stated above, at 3.25 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Asthma Dropsy & Bright Disease (duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. Howard, M. D.

10-13, 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chesterfield Va

DATE OF BURIAL 10-15-23 19

20 UNDERTAKER Daniel Easton

ADDRESS Same

TO PHYSICIANS: Please fill out this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 79919

Spec.—1-10-21—M&T / 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 31

CITY OF BALTIMORE: (No.) ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Payne.

(a) RESIDENCE NO. 540 Lambert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): Sept. 24-1922

7 AGE — Years: 1 — Months: 0 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Lorenzo Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Beatrice Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Friends

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Oct. 12, 1923, that I last saw her alive on Oct. 12, 1923, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (pulmonary, mediastinal, and multiple cold abscesses) -

(duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary): Generalized miliary tuberculosis

(duration) yrs. 11 mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray

(Signed) A. P. Mech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 10-15 1923

20 UNDERTAKER: Dunn & Eaton — ADDRESS: Balto

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79920

CERTIFICATE OF DEATH.

161-001 D 79920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Ernst

(a) RESIDENCE NO. 912 Russell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 30 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country)

14
Informant
(Address)

15
Filed ..... 19 .....
Registrar

OCT 15 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1923.

17
I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1923, to Oct - 11, 1923,
that I last saw h[illegible] alive on Oct - 11, 1923
and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Prematurity and congenital weakness.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P A Rothgues M. D.

, 19 (Address) Uni Hospital Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL Oct 13 1923

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health

CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 7992E

HEALTH DEPARTMENT—CITY OF BALTIMORE

57

D 7992E

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1918 Mount Royal Terrace St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mary Nixdorff

(a) Residence No. 1918 Mount Royal Terrace St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam Nixdorff

6-DATE OF BIRTH (month, day and year): March 6 1854

7-AGE: 69 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or....mln.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): At home 037

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Richard Dowell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Eliza Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant) Sam Nixdorff

(Address) 1918 Mt. Royal Terrace

OCT 15 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 14 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 14, 1923, that I last saw h.. alive on Oct 13, 1923, and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

~~about~~ 4 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syncope Cardiac

Patient 4 hours (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) G. Lotsch Ewalt M. D.

, 19 (Address) 2946 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

DATE OF BURIAL: Oct 17 1923

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that CAUSE OF DEATH is properly classified. Omissions should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79922

CERTIFICATE OF DEATH.

135

D 79922

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Chatham Rd ST. 15 WARD)

2-FULL NAME Mr William Carey Jones

(a) RESIDENCE NO. 3704 Chatham ST. Rd. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth J. Jones

6 DATE OF BIRTH (month, day, and year): Mar 19 1843

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~80~~ 80	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer): Iron Moulder

(c) Name of employer

047

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Sarah Keck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Howard E. Jones
(Address) 3704 Chatham Rd

15 Filed OCT 15 1923 19 ROBERT B. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to Oct 14, 1923, that I last saw h[illegible]alive on Oct 13, 1923, and that death occurred, on the date stated above, at 1.06 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma.
Follow operation on
Prostate in Case, last
6 yrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Angina
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of March 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F Geary M. D.

19 (Address) 101 W. Cleary St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Oct 16 1923

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79923

CERTIFICATE OF DEATH.

161-001

D 79923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 E. Madison St. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth May Manning

(a) RESIDENCE NO 1023 E. Madison St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct. 14/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				6

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Elbert Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Blume Baron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Elbert Manning
(Address) 1023 E. Madison St.

15 OCT 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity- eight mons. gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Haller, M. D.
(Coroner.)

10/14/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct 15 1923

20 UNDERTAKER Edward Bergen — ADDRESS 631 Arlington Ave

Exact statement of OCCUPATION must be given. Use instructions on back of certificate.

Spec—12-23-21—E.P.R.S.—400 Pks.

D 79924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 79924

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 4 Ward)

Registered No.

(If death occured in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Meyers

(a) Residence No. 14 Light st. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1834

7-AGE. 89 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

074

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- OCT 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13 19 23 to Oct. 12 1923

that I last saw him alive on Oct. 12 1923

and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho pneumonia (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum. X-ray

(Signed) L. A. Lally M. D

10-13. 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Zion et	Oct 15 1923

20-UNDERTAKER.	ADDRESS
C. J. Bruns Son	1811 Monty st

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that cause of death may be properly classified. Should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 79925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 79925

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Louisa Boucher

(a) RESIDENCE NO. Homewood apts. N. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/4/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John J. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Lehn.

13 BIRTHPLACE OF MOTHER (city or town) Balto, (State or country) Md.

14 Informant Louis Boucher (Address) JOHNS HOPKINS HOSPITAL Homewood Apt

15 Filed OCT 15 1923 19 ROBERT A. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1923. to Oct. 15, 1923.

that I last saw her alive on Oct. 15, 1923.

and that death occurred, on the date stated above, at 2 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma sigmoid

several (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Abscess peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? yes Date of 9/10/23

Was there an autopsy? no 10/13/23

What test confirmed diagnosis? Operation

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Oct 19

20 UNDERTAKER George J Smith

ADDRESS 157 Hollins

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79926

CERTIFICATE OF DEATH.

D 79926

188-003

I-PLACE OF DEATH

CITY OF BALTIMORE: (No.) North ave. (ST.) Washington (WARD) 19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ferdinand Grosley

(a) RESIDENCE No. 1516 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widower -

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
			7 days.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Da.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Grosley

11 BIRTHPLACE OF FATHER (city or town) Da.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Garland

13 BIRTHPLACE OF MOTHER (city or town) Da
(State or country)

14 Informant Kathern Grosley
(Address) 1516 W. Fayette St

15 Filed OCT 15 1923 192 RUBEN R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Injuries from Automobile accident (accidental)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John H. Monroe M.D.
(Coroner.)
Oct 15, 1923 (Address) 3692 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 15 1923
20 UNDERTAKER George J. Smith	ADDRESS 153

See instructions on back of certificate. Exact statement of OCCUPA- should state property classified.

Spec.—1-10-21—M&T—1500 Bks.

D 79927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 D 79927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Easton

(a) RESIDENCE NO. 830 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 6, 1879

7 AGE: Years 44 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer): Sh

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER John Easton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Caroline Easton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Hospital Records

(Address) Fayette & Eutaw

15 Filed OCT 15 1923 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Oct 14, 1923, that I last saw him alive on Oct 14, 1923, and that death occurred, on the date stated above, at 3 55 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 12.

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Harrison Wilson M.D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 19

20 UNDERTAKER: George Scott — ADDRESS: Holl

IMPORTANT.—The Cause of Death must be stated EXACTLY. PHYSICIANS should state DISEASE OR CONDITION RESULTING IN DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79923

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 E 29 st ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Rodgers

(a) RESIDENCE No. 1607 E. 29 st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Rodgers

6 DATE OF BIRTH (month, day, and year): Aug 7-1852

7 AGE — Years: 71 — Months: 2 — Days: — If LESS than 1 day, hrs. or..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: Patrick Davey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Eliza Fitzmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Margaret Rodgers 1607 E. 29 st

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Oct 13 1923

that I last saw her alive on Oct 13 1923

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Interval — Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?: residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. J. Rogers M. D.

1923 (Address) 500 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery Oct

DATE OF BURIAL: 16 1923

20 UNDERTAKER: Geo M. Frick & Son

ADDRESS: 811 N. Wolfe

TION is very important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

should be stated EXACTLY. PHYSICIANS should state

Every item of infor-

Spec.—6-9-19—H. P. Co.—1000 Bks.

Finstein

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79929

CERTIFICATE OF DEATH.

113 D 79929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Castle St. ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Finstein

(a) RESIDENCE. NO. 215 S. Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Philip Finstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Flowers Blessing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John M. Finstein (Address) 215 S Castle St.

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Oct.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923, to Oct 14, 1923, that I last saw h alive on Oct 14, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Dr. Heller, M. D.

10/15, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 15 1923
20 UNDERTAKER	ADDRESS
Lilly & Zirkin	403 N Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79930

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-B 79930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2937 Erdman Avenue ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Callis

(a) RESIDENCE NO. 2937 Erdman Avenue ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William T. Callis

6 DATE OF BIRTH (month, day, and year) 7/12/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Andrew J. Weltjen

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Christina Hilde-brand

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Wm. T. Callis
(Address) 2937 Erdman Avenue

15 Filed OCT 15 1923, 19 ROBERT N. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to Oct 14, 1923, that I last saw h alive on Oct 13, 1923 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Hepatitis

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites

..... (duration) ..... yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Walter A White M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/17 1923

20 UNDERTAKER ALBERT L. HILTZ, JR.

ADDRESS 1606 Chester

OCT 15 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79931 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79931

182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fallsway & Fawn ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Unknown

(a) RESIDENCE NO Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Police Dept

(Address) Eastern Dist

15 Filed OCT 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Supposed to be accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Geo. B. Horton, M. D.

Oct 13 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Oct 13 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

per Wm. E. Woodall

Exact statement of OCCUPA- should state property classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79932

CERTIFICATE OF DEATH.

90 ✓ D 79932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 S. Third ST. 96 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Forrester

(Residence in Baltimore: No. 5 S. Third St.; ....yrs., ...mos. ....ds.)

PHYSICIANS should state plainly, and in such manner that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 12, 1848
(Month) (Day) (Year)

7-AGE, 75 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brace-finisher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Forrester

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eucresia Norris

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Forrester

(Address) 5 S. Third St

15- Filed OCT 15 1923, 191.... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 - ~~1923~~ 1923, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1923, to Oct 14 - 1923 that I saw h[illegible] alive on Oct 14 - 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) [illegible] H. Krauss M. D.

10-14-, 191... (Address) 2919 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Oct 16, 1923

20-UNDERTAKER Burkert Dukes

ADDRESS 1739 Eager

Spec.—1-10-21—M&T—1500 Bks.

(Carroll)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79933

D 79933

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Gen Hospital St., 15 WARD)

2-FULL NAME Mrs Mary M Carroll.

(a) RESIDENCE NO. 210 Gough Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 18-1881

7 AGE: Years 42 Months 7 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Twister Jenner

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jas Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margt Gritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) 2421 Longwood st

OCT 16 1923, 19

Registrar Robert J. HATTISON, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-23

17 I HEREBY CERTIFY, That I attended deceased from 10-11-23, to 10-13-23,

that I last saw h alive on 10-13-23,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs., mos 2 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10-12-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jas Adamstown, M. D.

, 19 (Address) Mt Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mont Holy Redeemer DATE OF BURIAL Oct 16 1923

20 UNDERTAKER Josiah Lyder ADDRESS 1600 W North Ave

IMPORTANT. Every item of information called for in this CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should give the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79934 90 D 79934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7½ 4 Krebbs ave ST 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James F. McDonald

(Residence in Baltimore: No. 4 Krebbs ave Mt Washington St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-[redacted], [redacted], WIDOWED, OR [redacted] (Write the word.)

6-DATE OF BIRTH, Nov 10, 1853
(Month) (Day) (Year)

7-AGE, 70 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Washington

PARENTS.

10-NAME OF FATHER, Chas F. McDonald

11-BIRTHPLACE OF FATHER (State or Country), Washington Dc

12-MAIDEN NAME OF MOTHER Sadie S. Graves

13-BIRTHPLACE OF MOTHER (State or Country), Washington Dc

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw C. McDonald

(Address) 4 Krebbs Ave Mt Wash

15-

Filed ....., 191.....
Registrar.

51923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 10th 1923 to October 13th 1923, that I saw h[redacted] alive on October 13th 1923, and that death occurred, on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:

a. Chronic Myocarditis

.....

.....

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frederick H. Hyman M. D.

10-14-1923 (Address) 1710 E. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, NEW CATHEDRAL CEM

DATE OF BURIAL, 10/16, 191...

20-UNDERTAKER ROBERT S BRAKEMAN SON

ADDRESS COR CALHOUN HOLLINS

IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Buettner)

D 79935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St Agnes Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Buttner

(a) RESIDENCE NO. 908 W Franklin St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ~~Unknown~~ 1870

7 AGE: Years 53 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mrs Buttner

(Address) 908 W Franklin St

15 Filed 5 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 14, 1923, that I last saw h[er] alive on Oct 14, 1923, and that death occurred, on the date stated above, at 10 55 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/9/23

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/17 1923

20 UNDERTAKER: Jones & Poulson — ADDRESS: 14 E Fran

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79936 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79936

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3010 Presbury ST. 15 WARD)

2-FULL NAME Edward T. Murry Jr

(a) RESIDENCE NO. 3010 Presbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward T. Murry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Lura M. Hodgkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Hazel Armstrong (Address) 3010 Presbury St

15 Filed 10/15, 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Oct 15, 1923, that I last saw him alive on Oct 14, 1923 and that death occurred, on the date stated above, at 2.30, a m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? no Date of

Was there an autopsy? no -

What test confirmed diagnosis? Clinical -

(Signed) John S. Fenby, M. D.

10/15, 1923 (Address) 3542 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct 17 1923

20 UNDERTAKER George J Smith — ADDRESS 153 L Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79937 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79937

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Clarkson ST.: 23 WARD) 23

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Drobisch

(a) RESIDENCE. NO. 1519 Clarkson ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Paul H. Drobisch.

6 DATE OF BIRTH (month, day, and year) April, 8, 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75,	6,	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Christian Drobisch.
(Address) 1519 Clarkson St.

15 Filed 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 19 23 to Oct. 11, 19 23

that I last saw h er alive on Oct 11, 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio- sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. F. Harrison, M. D.

10/13 1923 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 16 1923
20 UNDERTAKER	ADDRESS
A Howard Evans	1428 E Baltimore St

THION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Deaves)

D 79933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79933

145-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hospital (ST.) 20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E Deaves

(a) RESIDENCE NO. 3400 Stafford (ST.)

(Usual place of abode) WARD

Length of residence in city or town where death occurred 18 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Chas P Davis

6 DATE OF BIRTH (month, day, and year): Aug. 15 - 1905

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
18	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hsk.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Robert E Seaman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Crawford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Husband.

(Address)

15 1923 . 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-23

17 I HEREBY CERTIFY, That I attended deceased from 10-13-23 to 10-13-23 19 ,

that I last saw h- alive on 10-13-23, 19 ,

and that death occurred, on the date stated above, at 11 38 m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Eclampsia Toxaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 10-13-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory findings

(Signed) Jno O'Hampsmith M. D.

, 19 (Address) Md Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 16 19 23

20 UNDERTAKER: Louis Heeman — ADDRESS: 332 Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79939

D 79939

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME John George Wirth, Jr.

(a) RESIDENCE No. 2419 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 7-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	—	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Geo. Wirth

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith G. Hall

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Hospital Records (Address)

15 [illegible] 19 .... Registrar

1 5 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 11th, 19 23, to Oct 15th 19 23.

that I last saw him alive on Oct. 15th 19 23

and that death occurred, on the date stated above, at 12 20 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction resulting from intra-uterine peritonitis. 8

(duration) yrs 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct. 13

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) N. N. Mead, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 16 19 23

20 UNDERTAKER: Louis Heemann — ADDRESS: 28 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16549 79940

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 79940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Wm. Chaplin

(a) RESIDENCE NO. 302 N. Bond ST ST., ... WARD ..

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 2 - 1915

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
8	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Irene Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed OCT 5 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 - 1923 to Oct 12 - 1923

that I last saw him alive on Oct 12 - 1923

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Acute rheumatic fever - 14 mos.

Endocarditis (mitral insufficiency) - 9 mos

Myocardial insufficiency - 9 mos.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. H. Meech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany Town

DATE OF BURIAL: Oct 6 19 23

20 UNDERTAKER: R. B. Grosh

ADDRESS: 1405 McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79941

CERTIFICATE OF DEATH.

197

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

2-FULL NAME James Mossow

(a) RESIDENCE NO. 426 N Stricker St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant R. E. Gross
(Address) 1405 N. McElderry St

15 Filed ..... 192 Robert P. Harrison, Registrar

T 151923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in chest

(duration) ..... yrs. a few hours mos ..... ds.

CONTRIBUTORY (Secondary) Shot by John Butler

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gerwig, M. D. (Coroner.)

10-15, 192 3 (Address) 117 N Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL 10-17 1923

20 UNDERTAKER R. E. Gross ADDRESS 1405 McElderry

THIS is very important. See Instructions on back of certificate. Every item of information should be stated EXACTLY. PHYSICIAN should state plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

D 79942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 79942

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at 617 N. Dallas St. Died enroute from Wash. D.C. ST., ... WARD)

2-FULL NAME Mattie Moore

(a) RESIDENCE No. 617 ~~XXXX~~ N. Dallas St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	widiw

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Moore

6 DATE OF BIRTH (month, day, and year): June 15/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	37	3	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Car-cleaner
(b) General nature of industry, business, or establishment in which employed (or employer): United Railways
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Henry Slaughter

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Susan Wiggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Susan Slaughter
(Address): Washington D.C.

15 Filed ..... 192 ..... Registrar

151923 Robert F. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis or Nephritis
(I think the former)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Alcoholism (duration) ... yrs. ... mos. ... ds.

(Signed) J. E. H. Pattison, M. D.
(Coroner.)

10/15/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	10/15 192[illegible]
20 UNDERTAKER	ADDRESS
Jos. M. Skinner	1625 Eutaw St

Cor.—1-12-23—M&T—100 Bks.

Should state exact statement of OCCUPATION. Be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79943 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 79943

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., 17 WARD)

2-FULL NAME Della Amanda Barnes

(a) RESIDENCE NO. Home for Incurables ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept. 20-1864

7 AGE — Years: 46 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Geo. Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland.

12 MAIDEN NAME OF MOTHER: Teresa Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland.

14 Informant (Address): Home for Incurables Guilford Ave & 21st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Oct 15, 1923, that I last saw h[illegible] alive on Oct 17, 1923, and that death occurred, on the date stated above, at 12 20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. over 3 mos — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hellers test + acetic acid

(Signed) W W B Mayo, M. D.

, 19 (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 10/16/23

20 UNDERTAKER: H E Hughes — ADDRESS: 1st N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79944 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 79944

CERTIFICATE OF DEATH.

18 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. My Jew Hospital ST.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ella Galloway

(a) RESIDENCE NO. 128 N. Calhoun St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced— (or) WIFE of S. John Galloway

6 DATE OF BIRTH (month, day, and year) Jan. 31. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER James P. Hughes

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Mrs. Howard W. Jackson

(Address) 3 Talbott Road

15 OCT 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-23

17 I HEREBY CERTIFY, That I attended deceased from 10 13 23, 19 to 10 14 23, 19, that I last saw h[illegible] alive on 10-14-23, 19, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH was as follows*

Chronic Hypertrophic Nephritis

(duration) yrs. 9+ mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 12 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Hughes, M. D.

, 19 (Address) 1st Glen Arbor.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Havre-de-Grace Md — DATE OF BURIAL: 10-17-23 19

20 UNDERTAKER: H.E. Hughes — ADDRESS: 434 N. Broadway

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 79945 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79945

CERTIFICATE OF DEATH. 21 100-001

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1135 W Cross St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Miles

(a) Residence No. 1135 W Cross St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, Married or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of Elsie Irene

6-DATE OF BIRTH (month, day and year) Dec 18 1896

7-AGE 26 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Jno T Miles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Bessie White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) E Lubensberg

(Address) 1135 W Cross St

15-

Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 14 1923

17-I HEREBY CERTIFY, That I attended deceased from Oct 9 23 to Oct 14 23

That I last saw him alive on Oct 14 23

And that death occurred, on the date stated above, at 7.10 P m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

5 ds

(Duration) yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E Lubensberg, M D

19 (Address) 1126 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cy	Oct 17 1923
20-UNDERTAKER.	ADDRESS
Jos Jacobs & Son	2178 Penn.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Physicians should state CAUSE OF DEATH precisely. Terms which may be properly classified.

Spec.—1-10 21—M&T—1500 Bks.

D 79946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79946

160

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 21 WARD)

2-FULL NAME Charlotte Ruth W Ilsworth

(a) RESIDENCE NO. 1044 Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Henry Wilsworth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Gramling

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) Walter Henry Wilsworth 1044 Bond St

15 Filed Oct 19 1923 Robert P. Harrison, Registrar

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1[illegible] 19[illegible]

17 I HEREBY CERTIFY, That I attended deceased from Oct. [illegible], 19[illegible], to Oct. [illegible], 19[illegible],

that I last saw h[illegible] alive on Oct [illegible], 19[illegible],

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) yrs. mos 17 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical examination

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mathews Cem

DATE OF BURIAL Oct 16 1923

20 UNDERTAKER Jas Jordan's Son

ADDRESS 217 S Paca St

MUST BE WRITTEN IN INK. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malnutrition

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79947

CERTIFICATE OF DEATH.

D 79947

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2101 Lake Montebello Terrace

CITY OF BALTIMORE: (No. McGuire Hosp X ST., 9 WARD)

2-FULL NAME Mrs. Margt Starkey X

(a) RESIDENCE NO. ~~1710 N. Fulton~~ ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 57 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Jno A Starkey

6 DATE OF BIRTH (month, day, and year): July 3rd 1866

7 AGE: Years 58 | Months 3 | Days 21 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED: HW

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Bastian Lenz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Himmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Patrick.

15 Filed ..... , 19 ..... Registrar

Robert P. Carlson, Asst. Public Health Clerk

115923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10 14 23

17 I HEREBY CERTIFY, That I attended deceased from 10-3-23, 19 ..., to 10-14-23,

that I last saw h alive on 10-14-23, 19 ...,

and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis, Diabetes Mellitus

14 days & 1 day yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10 4-23

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemical

(Signed) Jno A Stonebraker, M. D.

, 19 (Address) 1811 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Valley

DATE OF BURIAL: Oct 18, 23

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Eutaw Pl

IMPORTANT: Every item of information called for in this CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should state plainly the cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79948

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3010 E. Monument ST., 7 WARD)

2-FULL NAME Louise M. Lowery

(a) RESIDENCE NO. 3010 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Lowery.

6 DATE OF BIRTH (month, day, and year): Jan 25/1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Galto. City

PARENTS

10 NAME OF FATHER: James Pinkus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: L. Lysinek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Louise Pinkus

(Address): 3010 E. Monument St.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

151923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14th 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 8 1923 to Oct 14 1923

that I last saw h alive on Oct 14 1923 4 10 P.M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Acute Edema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

Signed [illegible] M. D.

Oct 15, 1923 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem. DATE OF BURIAL: Oct 17 1923

20 UNDERTAKER: Phil Herwig ADDRESS: 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79949

D 79949

CERTIFICATE OF DEATH.

161-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maty ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agnes Peregoy.

(Residence in Baltimore: No. West End Maty Hospt. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	White	Single

6-DATE OF BIRTH, 10 - 14, 1913.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establisbment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), West End Maty

PARENTS.

10-NAME OF FATHER, Chester Peregoy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lillian Yowell

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rhoda Johnson

(Address) 2820 Hudnick Ave

15- Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit C[illegible]

51923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 - 14, 1913.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-14-1913, to 10-14-1913, that I saw h[illegible]alive on 10-14-1913, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Separation of placenta

2 Hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth.

8 mo.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature], M. D.

10-14-, 1913 (Address) 2202 W North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Oct 15 1913
20-UNDERTAKER	ADDRESS
J. Wm McCally	305 Fulton

Fold here. PHYSICIANS should state clearly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 79950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79950

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1060 N Washington ST. WARD)

2-FULL NAME Joseph H Wisebaugh

(a) RESIDENCE NO. 1010 N Washington ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia wisebaugh

6 DATE OF BIRTH (month, day, and year): April 17 1857

7 AGE: 66 Years | 6 Months | 1 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Baltimore city

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Benjamin wisebaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sophia Wisebaugh

(Address): 1010 N Washington st

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

51923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 14, 1923.

that I last saw h[illegible] alive on Oct 14, 1923

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Grinhaus M. D.

Oct 15, 1923 (Address) 3600 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: Wm J. Hartley

ADDRESS: 816 N. Washington

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79951

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N. Patterson Park St., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer. W Kelty.

(a) RESIDENCE No. 1805 Patterson Park Ave. St., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma. C Kelty

6 DATE OF BIRTH (month, day, and year): Feb 5 1863

7 AGE: Years 60 Months 8 Days 9 If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: Wise Bros.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Kelty.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Cramer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Emma C Kelty 1805 P.P. Ave

15 Filed ..... Registrar

51923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10 — 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1923, to Oct 14th, 1923, that I last saw alive on Oct 14th, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

1 Heart + Brights Disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Elijah J Russell, M. D.

19 (Address) 156 W Mitchell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Oct 17 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 E. Fayette Ave

IMPORTANT. Every item of information called for in the following FORM OF CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79952

CERTIFICATE OF DEATH.

D 79952

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 24 E 20 St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula F. Jefferson

(a) RESIDENCE NO. 24 E 20 St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31st 1922

7 AGE: Years | 9 Months | 13 Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 24 E. 20th Balto Md.

PARENTS

10 NAME OF FATHER Cesar Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Hattie Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hattie Jefferson

(Address) 24 E 20 St

Filed OCT 16 1923

ROBERT N. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 17, 1923, that I last saw h[illegible] alive on Oct 17, 1923, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) General Exhaustion to Whooping Cough (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ged. F. Hall, M. D.

, 19 (Address) 426 E 23 Std

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem—

DATE OF BURIAL: Oct 16th 1923

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 2319 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79953

CERTIFICATE OF DEATH.

31 D 79953

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 McCulloh St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Walston

(a) RESIDENCE NO. 906 McCulloh St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 10th, 1908

7 AGE: Years 14 | Months | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER: Abraham Walston

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Viggie Addoh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Abraham Walston

(Address): 906 McCulloh St.

15 Filed OCT 16 1923 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/14th 1923

17 I HEREBY CERTIFY, That I attended deceased (from July 7th, 1923 to Oct. 14th, 1923 that I last saw him alive on Oct 14th, 1923 and that death occurred, on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

, 1923 (Address) 922 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: South Mills N. C.

DATE OF BURIAL: Oct 16 1923

20 UNDERTAKER: Samuel T. Hemsley

ADDRESS: Dr Bell

Burial Permit Clerk

NOTICE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79954

CERTIFICATE OF DEATH.

D 79954

1-PLACE OF DEATH University Hospital REGISTERED NO. X 129

CITY OF BALTIMORE: (No. ..... ST., ... WARD ....) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones,

(a) RESIDENCE NO. Phoenix, Balto. Co. Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Negro

5 Single, Married, Widowed, or Divorced. (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown, 1853

7 AGE Years 70 Months ... Days ... If LESS than 1 day, hrs. ... or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bonnie Jones
(Address) Phoenix Md

15 Filed OCT 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 . 1923 to Oct 14 . 1923

that I last saw HIM alive on Oct 14 . 1923

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No ..Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical findings

(Signed) W. S. Love M.D. M. D.

. 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phoenix Md — DATE OF BURIAL Oct 16 1923

20 UNDERTAKER Isaac Hawley — ADDRESS Phoenix Md

IMPORTANT. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79955

CERTIFICATE OF DEATH.

161-001 D 79955

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1017 Warner ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Minkins

(a) RESIDENCE. No. 1017 Warner ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. G. Minkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester Co. Md

12 MAIDEN NAME OF MOTHER: Irene Spence

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Irene S. Minkins
(Address): 1017 Warner St

15 Filed OCT 16 1923 ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13th, 1923, to Oct. 13, 1923, that I last saw h. alive on Oct. 13th, 1923 and that death occurred, on the date stated above, at 10, 15 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Shelton, M. D.

9/13/23 Address 923 N. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Oct 16 1923
20 UNDERTAKER	ADDRESS
C. J. Brandt Son	1101 Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ... should be stated EXACTLY. PHYSICIANS should state ... item of mor-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79956

CERTIFICATE OF DEATH.

161-001 D 79956

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 E Church ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Johnson

(Residence in Baltimore: No. 38 E. Church St.) 1 hr. 10 min. (yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, October (Month) 14 (Day), 1923 (Year)

7-AGE. ..... yrs. ..... mos. ..... da.

If LESS than 1 day, 1 hrs. 10 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Rudolph Lee

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Frances Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rudolph Lee Johnson

(Address) 38 E. Church St.

15-

Filed OCT 16 1923, 19..... REGINAL A. KRAUTH, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1923, to Oct 14, 1923, that I saw him alive on Oct. 14, 1923, and that death occurred, on the date stated above, at 11 30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Maternal hydramnios

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) Susanne R Parsons M. D.

10-14..., 1923 (Address) 1702 Westwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Ct	Oct 16, 1923
20-UNDERTAKER	ADDRESS
C. W. Brauer's Son	1018 W. Monroe

Important. See instructions on back of certificate. PHYSICIANS should state exactly where disease was contracted, as that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

Rosie Beeley. X 1/5-3

D 79957. HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79957

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. South East Gen Hosp ST., WARD) N

2-FULL NAME Mrs Rosie Beeley

(a) RESIDENCE NO. Lund Md: ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington DC (State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Maryland Emergency Hospital (Address)

Filed OCT 16 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15 1923

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1923, to October 15, 1923, that I last saw her alive on October 15, 1923, and that death occurred, on the date stated above, at 6 Yo 9 m.

The CAUSE OF DEATH* was as follows:

Cancer Abdominis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Localized peritonitis

Uncertain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of October 13/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Cameron, M. D.

19 (Address) 211 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lincoln Park Md.

DATE OF BURIAL 10/16 1923

20 UNDERTAKER E & J Hasle

ADDRESS 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 79958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79958

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 E 28th St. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Insley Brewington

(a) RESIDENCE. No. 300 E 28th St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ~~5~~ mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

17

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1908

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
15		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward Insley Brewington

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lilian Ingram Parry.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Ed W Brewington
(Address) 300 E 28th St Balto

Filed OCT 16 1923 RUBLAI N. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 19, 1923,

that I last saw him alive on Oct 19, 1923,

and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Hemolyticus

Pneumonia & Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacterial

(Signed) Walter Md, M. D.

19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	10/16/ 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell,	1701 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 79959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79959

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1626 Vincent St ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Brayton

(a) RESIDENCE. No. 1626 Vincent St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Brayton

6 DATE OF BIRTH (month, day, and year) July 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co. Va

PARENTS

10 NAME OF FATHER Wm. Brayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Elizabeth Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va.

14 Informant Isaac Brayton (Address) 1720 Lorman St.

15 Filed OCT 16 1923 19 ROBERT E. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1923, to 10-14, 1923, that I last saw him alive on 10-13, 1923, and that death occurred, on the date stated above, at 2.72 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 10/17 1923

20 UNDERTAKER — ADDRESS 301

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION should state plain terms, so that it may be properly classified. PHYSICIANS should state as stated EXACTLY. Omission of any item of information

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79960

D 79960

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Gen Hosp. ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline Smithson

(a) RESIDENCE NO. Y.W.C.A. Bldg ST., WARD Port Deposit

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4-1900

7 AGE Years 23 Months 3 Days 22 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Armory, Smithson

PARENTS

10 NAME OF FATHER Port Deposit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Deposit.

12 MAIDEN NAME OF MOTHER Mary Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Patient Caroline Smithson Y.W.C.A.

15 Filed 19

OCT 16 1923

ROBERT M. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16-1923

17 I HEREBY CERTIFY, That I attended deceased from 9-28-23 19 , to 10-16-23 19 ,

that I last saw h alive on 10-16-23 19 ,

and that death occurred, on the date stated above, at 4 55 a m.

The CAUSE OF DEATH* was as follows:

Grippe.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pyelitis, Chr. Interstitial Nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Examination

(Signed) No Autopsy taken. , M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Deposit, Md.

DATE OF BURIAL Oct 19 1923

20 UNDERTAKER Leeg. Patterson

ADDRESS Perryville Md.

NOTE—Every item of information should be stated EXACTLY. PHYSICIANS should state DISEASE OR CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

96984

D 79961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 79961

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Paul Bluhme

(a) RESIDENCE NO. 723 W. Barre ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1y 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): Sept 13 1923

7 AGE — Years: 0 — Months: 1 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adolf Jacob.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ruth Bluhme

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL

(Address)

15 Filed OCT 16 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Oct 14, 1923, that I last saw him alive on Oct 14, 1923, and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) ∧

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: 10/16 1923

20 UNDERTAKER: H. H. Wittstadt 153

ADDRESS: Lombard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79962

CERTIFICATE OF DEATH.

129 D 79962

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1107 Ashland Ave (St.); (Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph White

(a) RESIDENCE. No. 1107 Ashland Ave (Usual place of abode) WARD. 16

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or Wife of)~~ Carrie White

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie White (Address) 1107 Ashland Ave

15 Filed OCT 16 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 12, 1923, that I last saw him alive on Oct 11, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) A Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

10/15, 1923 (Signed) Walter O White Jr, M. D. (Address) 1107 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westerny Cemetery	10/16 1923

20 UNDERTAKER Robert F Williams ADDRESS 1515 McElderry St

IMPORTANT: Every item of information called for in this CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79963 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79963

CERTIFICATE OF DEATH.

7H-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 McCulloh ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Marie High

(a) RESIDENCE NO. 1907 McCulloh ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph High

6 DATE OF BIRTH (month, day, and year) Oct 25-1873

7 AGE 50 Years 9 Months 20 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ..... D 10

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) unknown

14 Informant Gertrude Freeman

(Address) 1907 McCulloh St

15 Filed OCT 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/4 1923 to 10/14 1923, that I last saw h[illegible] alive on 10/14 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Paralysis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) B M Clutter, M. D.

10/15 1923 (Address) 2134 N. C

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 10-17 1923

20 UNDERTAKER George I-A Gelston ADDRESS 1735 Druid Hill Ave

MEDICAL CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79964 D 79964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amy Cooper

(a) RESIDENCE NO. 521 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE — Years: 40 — Months: 0 — Days: 0 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Henry Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed OCT 16 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923. to Oct 14, 1923.

that I last saw her alive on Oct 14, 1923.

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebellar Hemorrhage

2 hrs?

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary): Aortic Stenosis — Not Known
Essential hypertension
Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Woman. autopsy

(Signed) R. P. Hamon, M. D.

10/15, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 10-17-1923

20 UNDERTAKER: George L. A. Gilson — ADDRESS: 1035 Druid Hill Ave

DEATH is very important. See Instructions on back of certificates.

TION is very important. Exact statement of OCCUPA-

should be stated EXACTLY. PHYSICIANS should state AGE

RECORD. Every item of infor-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79965

CERTIFICATE OF DEATH.

D 79965

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 10th (Brooklyn) ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frederick Schafer

(a) RESIDENCE NO. 1711 10th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 16 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	29	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Fredk L Schafer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henriette Gardner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Augusta Coleman

(Address) 1108 Hull St

15 Filed OCT 16 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 9 1923 to Oct 14 1923,

that I last saw h[illegible] alive on Oct 12 1923,

and that death occurred, on the date stated above, at 7-9 m.

The CAUSE OF DEATH* was as follows:

Gangrene of foot

(duration) no yrs. no mos 16 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) no yrs. no mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Diseased foot

(Signed) Raymond Ellenberg, M. D.

(Address) 1 Belleland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Oct 17 1923
20 UNDERTAKER John Merrick	ADDRESS 2008 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 79966 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79966

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1041 Compton St. ST., ... WARD)

2-FULL NAME Caroline Robinson.

(a) RESIDENCE NO 1041 Compton St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~
~~HUSBAND OF~~
(or) WIFE of Lazarus Robinson.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ---- Ledlein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant William Robinson. (son)
(Address) 411b Philadelphia Road.

15 Filed OCT 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Oct, 15, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Oct 16 1923

20 UNDERTAKER Margaret A. Flynn — ADDRESS 1422 Light St.

Sec instructions on back of certificate. Exact statement of OCCUPA- PHYSICIANS should state ... properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79967.

CERTIFICATE OF DEATH.

129 D 79967.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1102 W Pratt ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Kratz

(a) RESIDENCE NO. 1102 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Dec 21 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George T Kratz

(Address) 1102 W Pratt st

15 Filed Oct 19 23 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from 9/19/ 19 23, to 10/14/ 19 23,

that I last saw her alive on 10/14/23, 19 ,

and that death occurred, on the date stated above, at 2 1 m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

" Nephritis - Diffuse

Syncope (duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Oct 19 23 (Address) 710 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ot Pleasant — DATE OF BURIAL: Oct 25 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Lombard

IMPORTANT. Every item of information called for by this RECORD should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 79968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79968

CERTIFICATE OF DEATH.

179

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Castle

(a) RESIDENCE No. 1724 Frederick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 29

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W B & A R R. Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 Informant Annie E Castle

(Address) 1724 Frederick ave

15 Filed ..., 192... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned by Current in contact with Electric Wire

(duration) ... yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Accident

(duration) ... yrs. ... mos. ... ds.

(Signed) J. K. Somerville M. D.

(Coroner.)

10-16 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Frederick Md.

DATE OF BURIAL Oct 17 1923

20 UNDERTAKER Harry N Mumaugh 4204

ADDRESS Edgewood Ave

Very important. See instructions on back of certificate. Exact statement of OCCUPATION. PHYSICIANS should state that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79969

CERTIFICATE OF DEATH.

46 D 79969

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 E. Biddle St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Schmidt.

(a) RESIDENCE NO. 1223 E. Biddle St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Peter Schmidt

6 DATE OF BIRTH (month, day, and year): Dec 24 1860

7 AGE: Years 62 years. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Virginia Va.

PARENTS

10 NAME OF FATHER: John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Wann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia Va.

14 Informant: Mrs Mary Shea. (Address) 1223 E. Biddle st

15 Filed OCT 16 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1923, to Oct. 12th, 1923,

that I last saw her alive on Oct 12th, 1923,

and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Original Exam

(Signed) Geo. Winegeart Dorsey M. D.

10/15/23 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery — DATE OF BURIAL: Oct. 16 1923

20 UNDERTAKER: Geo. J. Ruth — ADDRESS: 1735 Hayford ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79970

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 207 Fraymore Road. (St.,) (Ward) 11

2-FULL NAME Christopher F Heck

(a) RESIDENCE No. 207 Fraymore Rd St., WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Heck

6 DATE OF BIRTH (month, day, and year): Oct. 16 1868

7 AGE — Years: 54 — Months: 11 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frederick C. Heck.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Julia Wallpuhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: C. F. Heck.

(Address): 207 Fraymore Road.

15 Filed OCT 16 1923 RUBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Oct 13, 1923, that I last saw h alive on Oct. 12, 1923, and that death occurred, on the date stated above, at 6 3/4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

Cardiac decompensation

(duration) yrs. (Medical Hosp) mos. ds.

CONTRIBUTORY (Secondary) hypertension & atero sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Semmes, M. D.

10/14, 1923 (Address) 4102 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery.

DATE OF BURIAL: Oct. 16 1923

20 UNDERTAKER: George F. Rutter

ADDRESS: 1735 Harford ave

NAME OF DECEASED MUST BE GIVEN IN FULL, and AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79971

CERTIFICATE OF DEATH.

101-001 V

D 79971

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 E. Baltimore ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis C. Sander

(Residence in Baltimore: No. 1701 E. Baltimore St.; Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, December 26, 1858
(Month) (Day) (Year)

7-AGE, 64 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Sander

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katharine Jung

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sanders

(Address) 1701 E. Balto. St.

15-

Filed ....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1923, to Oct. 14 1923, that I saw her alive on Oct. 14 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia and Heart Disease

(Duration) 4 days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Miller M. D.

Oct 15, 1923 (Address) 1924 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct. 17, 1923
20-UNDERTAKER	**ADDRESS**
H. Sander & Sons	1710 Fleet St.

Important. See instructions on back of certificate. Physicians should state plainly and EXACTLY. Exact statement of OCCUPATION is very necessary that the cause may be properly classified.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 79972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79972

CERTIFICATE OF DEATH.

49

REGISTERED NO. 116

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 E. Baltimore ST.; 26 WARD)

2-FULL NAME Orlah Mannion

(a) RESIDENCE. No. 3423 E. Baltimore St., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Mannion

6 DATE OF BIRTH (month, day, and year) Sept. 8 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Gillespie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thos. Mannion (Address) 3423 E. Balto St.

15 Filed OCT 16 1923 Registrar ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Oct 14, 1923, that I last saw her alive on Oct 12, 1923, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder with general Carcinosis

(duration) 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Exploratory

(Signed) M. J. McAvoy, M. D.

9/16/23 (Address) 839 S. Edwards

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	10/17 1923

20 UNDERTAKER J. A. Moran ADDRESS 300 E. Balto St.

DO NOT WRITE IN PLAN TERMS. Every item of information should be stated EXACTLY. PHYSICIANS should state DISEASE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79973

CERTIFICATE OF DEATH.

31 D 79973

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 W. Lanvale ST., WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth M. Butt

(a) RESIDENCE No. 3012 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Butt

6 DATE OF BIRTH (month, day, and year): Feb 9th 1877

7 AGE — Years: 46 — Months: 8 — Days: 5 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Georg Hammil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Mary Schatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John Butt 3012 W. Lanvale St.

15 Filed OCT 16 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11th, 1923, to Oct 14, 1923, that I last saw h alive on Oct. 14th, 1923, and that death occurred, on the date stated above, at 8 40 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Benj. Kader M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 10/18/1923

20 UNDERTAKER: J. J. Moran — ADDRESS: 300 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 159-1020

D 79974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 N Washington ST., WARD) 7

2-FULL NAME Leo Frederick Grill

(a) RESIDENCE NO. 1024 N Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 1923

7 AGE — Years | Months | Days: 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Franklin A. Grill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gladys Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Frederick A. Grill

(Address): 1024 N Washington St

15 Filed OCT 16 1923 19 Registrar

ROBERT A. KRAUTZ

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-15 1923 to 10-16 1923

that I last saw h alive on 10-16 1923

and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Malformation

CONTRIBUTORY (Secondary) Premature infant (duration) yrs. mos 10 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~unknown~~

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F Fred Grill M. D.

10-15-23 (Address) 1024 N Wash St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 17 1923

20 UNDERTAKER: Henry Rosch & Son — ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

1429 Bond.

D 79975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79975

CERTIFICATE OF DEATH.

11/29

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. E. Monument ST., WARD

2-FULL NAME Benjamin Hoffman

(a) RESIDENCE NO. ..... Friendly Inn ST., ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Hoffman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): L. Lewis 1439 E. Baltimore

15 Filed OCT 16 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 16, 1923,

that I last saw h alive on Oct 16, 1923,

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

1. Arteriosclerotic Heart Disease - Decompensated
2. Myocardial failure - Emphysema
3. Cardiac asthma
4. Chronic Nephritis
5. Pulmonary Edema (Terminal) (duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Gastric upset

Acute Bronchitis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor I. Fry, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 10-16 19 23

20 UNDERTAKER: Just Lewis — ADDRESS: 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—I-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79976

CERTIFICATE OF DEATH.

90 D 79976

1-PLACE OF DEATH Hebrew Aged Home

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 105 Aisquith St. ST., ... WARD) 5

2-FULL NAME Samuel Soloman

(a) RESIDENCE No 105 Aisquith St,, ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russiaa

14 Informant J. Lewis

(Address) 1439 E. Balto.,

15 Filed OCT 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10- 16- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probally Cardiac Dilatation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Valvular Innsufficency (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paul, M. D. (Coroner)

Octr 16, 1923 (Address) 508 E. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Russdale	10-16-1923
20 UNDERTAKER Jacob Lewis	ADDRESS 1439 E. Balto

PHYSICIANS should state properly classified. Exact statement of OCCUPATION. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79977

CERTIFICATE OF DEATH.

31 ✓ D 79977

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 W. Belvidere ST., WARD)

2-FULL NAME Max Greenberg

(a) RESIDENCE NO. 325 W. Belvidere Ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lena Greenberg

6 DATE OF BIRTH (month, day, and year) March 18 79

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
50	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Minsk, Russia

PARENTS

10 NAME OF FATHER Moses Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Greenberg
(Address) 117 W. 36th Street

OCT 16 1923
Filed

ROBERT R. KRAUSER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2nd, 1923, to Oct. 9th, 1923.

that I last saw him alive on Oct. 9th, 1923.

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis
Chronic Bronchitis and Asthma

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical data

(Signed) Harry E. Levit, M. D.

10/15, 1923 (Address) 2221 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebrew Rozedale — DATE OF BURIAL 10/16 23

20 UNDERTAKER Jack Sears — ADDRESS 1434 E Balto

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 79978 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 1990

City of BALTIMORE: (No. 2 Four 1/2 St., Brooklyn Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Catherine Johnson

(a) Residence No. 2 Four 1/2 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jacob Johnson

6-DATE OF BIRTH (month, day and year): June 25/1858

7-AGE: 65 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: George W Knight

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Ann E Shanks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Snow Hill Maryland

14- (Informant) Mr Jacob Johnson (Address) 2 Four 1/2 st

15- Filed ... 192... Registrar.

Robert P. Harris

C1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 15 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923 to Oct 15, 1923

that I last saw h[illegible] alive on Oct 15 1923

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooks M. D.

, 1923 (Address) Brooklyn Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Oct 19 1923

20-UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Instructions: Please write plainly. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Gilster)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79979

101-001

D 79979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2911 S Paca ST.: 20 WARD)

2-FULL NAME Aug H Gilster

(a) RESIDENCE. No. 50.1 Hulaka ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Gilster

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58.	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Gilster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmine Maier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Gilster (Address) 201 S. Pulaski St.

15 Filed OCT 16 1923 19 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Oct. 15, 1923, that I last saw h alive on Oct 15, 1923, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

(Address) 302 W Fred

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Cemetery — DATE OF BURIAL Oct. 18 1923

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Frederick Ave.

X ... DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79980

CERTIFICATE OF DEATH.

B 79980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2910 Walbrook Ave ST., 15 WARD)

2-FULL NAME Louisa E. Marks

(a) RESIDENCE No. 3033 Grayson St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis E. Marks.

6 DATE OF BIRTH (month, day, and year): Oct 2, 1854.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
69	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Godfrey Scheyett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Kirchbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia E. Schetlich

(Address) 335 E Gay St.

15 Dec 3 1923 . 19 .....

Registrar

Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14. 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Oct 14, 1923, that I last saw her alive on Oct 14, 1923, and that death occurred, on the date stated above, at Oct. 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): chronic nephritis

(duration) 10. yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) John Zierler, M. D.

19 — (Address) 1123 Poplar Grove

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 17. 1923

20 UNDERTAKER: Mr & Mrs. John H. Teufel & Son — ADDRESS: 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79981

CERTIFICATE OF DEATH.

74-001 D 79981

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2526 Guilford Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Freitag

(a) RESIDENCE NO. 2526 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Freitag

6 DATE OF BIRTH (month, day, and year): Sept 28-1843

7 AGE — Years: 80 — Months: — — Days: 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Grenzebach.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna. E. Schnitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Anna E Engel 2526 Guilford Ave

OCT 16 1923 Rosary F. Harrison, Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 15. 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1923, to Oct 14, 1923, that I last saw her alive on Oct 14, 1923, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Alternate-hemiplegia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Complete motor Paralysis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances A. Carpenter M. D.

(Address) 2101 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore.

DATE OF BURIAL: Oct. 18. 1923

20 UNDERTAKER: Mrs. Mrs John H. Teufel & Son

ADDRESS: 824 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. (Mary Bishop)

D 79982 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 79982

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bishop Mary Bishop

(a) Residence No. Preston St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widowed

~~6a-If married, widowed, or divorced~~ HUSBAND of (or) ~~Wife~~ of Robert Bishop

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 72 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Md

PARENTS.

10-NAME OF FATHER. David Lee

11-BIRTHPLACE OF FATHER (city or town). (State or Country).

12-MAIDEN NAME OF MOTHER. Susan Carran

13-BIRTHPLACE OF MOTHER (city or town). (State or Country).

11 (Informant) Sister Florence

(Address) Preston St. Balto

15- Filed 192 Robert P. Harrison, Registrar.

OCT 6 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-16-23

17- I HEREBY CERTIFY, That I attended deceased from 10/16/23 19.. to 10/16 19 23 that I last saw h. alive on 10/15 19 23 and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Uremia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wyatt M D

10/16 19 23 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. DATE OF BURIAL. Oct 16 1923

20-UNDERTAKER. H. C. Windsor & Son ADDRESS 914 Greenmt Ave

instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79983 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79983

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2511 Elsinore Ave. (Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob George Hartman

(a) RESIDENCE. No. 2511 Elsinore Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Sophia S. Hartman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Coach Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Casper Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna M. Lucken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Sophia S. Hartman (Address) 2511 Elsinore Ave

15 Filed OCT 16 1923, 19 Robert F. Harrison, Registrar

OCT 16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Oct. 15, 1923, that I last saw him alive on Oct 15, 1923, and that death occurred, on the date stated above, at 7:50 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Generalized Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

OCT 15 1923 (Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ New Cathedral DATE OF BURIAL OCT 17 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

OCT 16 1923

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 79984

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 28 WARD)

REGISTERED NO. 1321

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis H. Schroder

(a) RESIDENCE NO. 4110 Groveland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Frances Schroder

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work

(b) General nature of industry, business, or establishment in which employed (or employer) Claim adjuster

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sigismund C Schroder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Copenhagen

12 MAIDEN NAME OF MOTHER Carolina Free

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Flora V. Schroder

(Address) 4110 Groveland ave

15 Filed OCT 18 1923, 19

Robert F. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1923, to Oct. 15, 1923, that I last saw him alive on Oct. 14, 1923, and that death occurred, on the date stated above, at 5 10 a m.

The CAUSE OF DEATH* was as follows:

Cardiac embolus?

Cerebral embolus?

8 minutes

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Suprapubic Cystostomy

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 4 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald C Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Oct 17 19 23

20 UNDERTAKER Wm J Hickner & Sons — ADDRESS Rockford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stone in Bladder

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79985

CERTIFICATE OF DEATH.

90 D 79985

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 15 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie L. Hammer

(a) RESIDENCE NO. 3508 Edgerton Road (St.) ..... (Ward) .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D. Hammer

6 DATE OF BIRTH (month, day, and year) May 28 1867

7 AGE — Years 56 | Months 4 | Days 18 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Geo. Schwinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Heingman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Wm D. Hammer
(Address) 3508 Egerton Rd

15 Filed ..... 19 .....
Registrar
Burial Permit Clerk.

61923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1923

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1923, to October 16, 1923,
that I last saw h[er] alive on October 16, 1923,
and that death occurred, on the date stated above, at 12 10 m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer
Chronic Myocarditis
(duration) yrs. 16 mos ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Est Nor
Did an operation precede death? No Date of Oct 13-1923.
Was there an autopsy? No
What test confirmed diagnosis? Clinical Operation

(Signed) Howard Wilson, M. D.
, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Oct 18 1923

20 UNDERTAKER Wm Pickuer & Sons | ADDRESS Md Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 79986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5263 St Charles ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Whaley

(a) RESIDENCE. NO. 5263 St Charles ST., ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida A Whaley

6 DATE OF BIRTH (month, day, and year) Dec 9-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Sentrial Whaley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Dater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Ida A Whaley 5263 St Charles ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

T 161923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1922, to Oct 14- 1923, that I last saw him alive on Oct 14- 1923 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscoped

(Signed) E E Nichols, M. D.

10/15 1923 (Address) Pikesville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 17 1923
20 UNDERTAKER	ADDRESS
Leon Cook	502 E Hath.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79987. 46 D 79987.

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 E Hoff Ave ST., 24 WARD)

2-FULL NAME Pauline Lange

(a) RESIDENCE NO. 700 E Hoff Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a ~~If married, widowed, or divorced~~ (or) WIFE of Frank Lange

6 DATE OF BIRTH (month, day, and year) July 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	78	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Martins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Gertrude Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Mary Lange. (Daughter) 700 E Hoff Ave.

15 Filed ..... 19 ..... Registrar

16 1923 Robert F. [illegible] Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19 1922 to Oct 14 1923, that I last saw he alive on Oct 13 1923, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of vulva

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm Lobstein, M. D.

10-15 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co — DATE OF BURIAL 10-17 1923

20 UNDERTAKER E & B Harle — ADDRESS 115 E Hoff St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79988

99-002 D 79988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2829 Bernard ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn R Hopkins

(a) RESIDENCE. NO. 2829 Bernard st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 8 1896

7 AGE: Years 26; Months 8; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Charles F Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ada C Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ada C Burke

(Address) 2829 Bernard st

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1909, to Oct 16, 1923, that I last saw h[illegible] alive on Oct 16, 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia (duration) 1 yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis Asthma (duration) 14 yrs. 7 mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Oct 16 1923 (Address) 1126 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem DATE OF BURIAL: Oct 19 1923

20 UNDERTAKER: CHENOWETH & SON ADDRESS: 3617 CHESTNUT AVE.

Oct 16 1923 Robert F. Griffith Burial Permit Clerk.

THIS CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79989

100-001

D 79989

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 826 (Stirling) ST., 10 WARD)

2-FULL NAME Inez Coler

(a) RESIDENCE NO. 826 (Usual place of abode) Stirling ST., WARD

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs. 15 mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not married

6 DATE OF BIRTH (month, day, and year) Mar 24, 1922

7 AGE — Years 1 Months 6 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry J. Coler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harry Coler (Address) 823 Stirling St.

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 23 to — 19 — that I last saw him alive on Nov. 19 23 and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Edema Lungs

(duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) Exhaustion, etc.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Mayfield Boyle M. D.

11/9 19 23 (Address) 1201 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Nov 11 19 23

20 UNDERTAKER Geo. W. Ort & Elliott — ADDRESS 1725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be stated EXACTLY. PHYSICIANS should state

This is a PERMANENT RECORD. Every item of information should be carefully supplied.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso'n]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nurse is every reason
to believe that there was
something else the matter
with the deceased; but she
was virtually moribund
when I saw her.

Dr. Ramsay

Cor.—1-12-23—M&T—100 Bks.

D 79990 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79990

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

2-FULL NAME James W. Johnson

(a) RESIDENCE NO 1709 Brentwood Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Bird

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Bessie E. Covington
(Address) 1921 W. Lafayette Av

15 Filed OCT 1 1923 ROBERT R. KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) Accidentally

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 16, 1923 (Address) 2307 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 10/17 1923

20 UNDERTAKER Jas. H. Lewis — ADDRESS 203 Mendenhall

Very important. See items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 79991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 79991

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Hargrove ST., 17 WARD)

2-FULL NAME Priscilla H. Chambers

(a) RESIDENCE NO. 2023 Hargrove ST., of WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mch. 21, 1871

7 AGE: Years 52 | Months 6 | Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bolto Md

PARENTS

10 NAME OF FATHER: John. Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mamie Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): D. C. Moody 722 S. Hanover St

15 Filed OCT 17 1923 ROBERT A. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 15, 1923, that I last saw h[illegible] alive on Oct 14, 1923, and that death occurred, on the date stated above, at 1:50 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis and Acute Edema of pericardium

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis parotitis (duration) yrs. mos. 5 ds.

Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Hull, M. D.

, 19 (Address) 722 S. Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 10/17 1923

20 UNDERTAKER: Jas. H. Dennis — ADDRESS: 1303 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be stated EXACTLY. PHYSICIANS should state

PERMANENT RECORD. Every item of information

supplied.

Spec.—1-10-21—M&T—1500 Bks.

16697 D 79992

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 79992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Marian Williams

(a) RESIDENCE NO. 1203 E. Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 20 - 1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chase Md

PARENTS

10 NAME OF FATHER: Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL
(Address)

15 Filed OCT 17 1923 ROBERT B. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Oct 14, 1923, that I last saw her alive on Oct 14, 1923, and that death occurred, on the date stated above, at 5-15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Chronic myocarditis
(Final illness 3 months)

(duration) 10 yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary): Heart blood capsule

(duration) 15 yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Clark Coolidge Penn Wash Co

What test confirmed diagnosis?

(Signed) R R Harmon, M. D.

Oct 15, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chase Interment md — DATE OF BURIAL: Oct 17 1923

20 UNDERTAKER: Edward Bryson — ADDRESS: 631 Orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 79993 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 79993

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH 1428 mince alley

CITY OF BALTIMORE: (No. William J Johnson St.; 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J Johnson

(a) RESIDENCE. No. 1428 mince alley Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 6 1888

7 AGE: 35 (Years / Months / Days; If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): V. C.

PARENTS

10 NAME OF FATHER: Holland Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): V. C.

12 MAIDEN NAME OF MOTHER: Cornelia Diffle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): V. C.

14 Informant: Cornelia Johnson

(Address): 1428 mince alley

15 Filed . 19 Registrar

OCT 7 1923 ROBERT P. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1923, to Oct 15th, 1923, that I last saw h alive on " 13th, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

10-16 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: Oct 17 1923

20 UNDERTAKER: Mrs. R. L. Elliott ADDRESS: 172 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D 79994

CERTIFICATE OF DEATH.

D 79994

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 S. Hanover St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Samuel Hopkins.

(a) RESIDENCE. No. 871 S. Hanover St., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hopkins.

6 DATE OF BIRTH (month, day, and year) March 1-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 1 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Hopkins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Martha Ludwig (Daughter)
(Address) 871 S. Hanover St.

15 Filed OCT 17 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1921. to Oct 13. 1923.
that I last saw h in alive on Oct 13. 1923.
and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. X. Buntz, M. D.

19 (Address) 3042 Hudson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL Oct. 17 1923.

20 UNDERTAKER Lilly & Fisher

ADDRESS 402 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Zarbs ✓

D 79995 HEALTH DEPARTMENT—CITY OF BALTIMORE D 79995

CERTIFICATE OF DEATH.

143-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen (Hospital) ST., WARD)

2-FULL NAME Mrs Hedwig Zarbs.

(a) RESIDENCE NO. 2226 Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21 - 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	19	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Zarecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Leslie and Geo. Zarbs.

(Address) 2226 Eden St.

15 Filed OCT 17 1923 H. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-8-23, 19, to 10-18-23 19,

that I last saw her alive on 10-18-23, 19,

and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Pregnancy. Ectopic.

(duration) yrs. mos 4 2 ds.

CONTRIBUTORY (Secondary) Embolism. 0 0 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? Yes Date of 10-8-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Geo Adamstein, M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Oct 19-1923

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21. MAT. 1500 Blks.

D 79996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79996

X 41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospital WARD)

2-FULL NAME Mrs Edna Woods.

(a) RESIDENCE NO. Reisterstown Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Small white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Milton A. Woods

6 DATE OF BIRTH (month, day, and year): Jan 15 1889

7 AGE: Years 34 Months 8 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Albert Fuss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredrick Co Md

12 MAIDEN NAME OF MOTHER: Margaret Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Milton A Woods

(Address): Glyndon Md

15 Filed OCT 17 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-11-23 to 10-16-23.

that I last saw her alive on 10-16-23

and that death occurred, on the date stated above, at 4 PM

The CAUSE OF DEATH* was as follows:

Septicemia e
Multiple abscess
formation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Tonsils; cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? Yes Date of 10-13-23

Was there an autopsy? No

What test confirmed diagnosis? clinic & symptoms

(Signed) Jno A Dempsey M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Grove Cemetery Carroll Co Md

DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: J. F. Ellis

ADDRESS: Reisterstown Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

D. 79997. HEALTH DEPARTMENT—CITY OF BALTIMORE D 79997.

123

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for the Women of Md ST., 14 WARD)

2-FULL NAME Sarah Elizabeth Buchanan Tappan

(a) RESIDENCE No. 1419 Bolton Str. Balt, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married-

5a If married, widowed, or divorced (or) WIFE of William Tappan

6 DATE OF BIRTH (month, day, and year) Mar. 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Steubenville Ohio-

PARENTS

10 NAME OF FATHER James Edward Buchanan

11 BIRTHPLACE OF FATHER (city or town) Steubenville (State or country) Ohio

12 MAIDEN NAME OF MOTHER Elizabeth Glendenning

13 BIRTHPLACE OF MOTHER (city or town) Ohio- (State or country)

14 Informant Elizabeth Tappan (daughter) (Address) 1419 Bolton Str.

15 Filed 19 Registrar

CT 171923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 7 .1923. to Oct 16 .1923.

that I last saw her alive on Oct. 16 .1923.

and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic ileus following cholecystectomy for cholecystitis & cholelithiasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes - Date of Oct 12/23

Was there an autopsy?

What test confirmed diagnosis? Physical examination

(Signed) J. F. Tuff M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Oct 18 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 1500 N. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Removal of Gall Bladder
& Gall stones.

Spec.—1-10-21—M&T—1500 Bks.

D 79998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 79998

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Lawrence ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Presser

(a) RESIDENCE NO. 1427 Lawrence ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6. 1923

7 AGE — Years: — Months: 4 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William M. Presser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rhoda Clements

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Wm M. Presser

(Address): 1427 Lawrence St

15 Filed OCT 17 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15. 1923 to Oct 16. 1923

that I last saw him alive on Oct 16. 1923

and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens, M. D.

10/16/1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: E. Howard Evans — ADDRESS: 1420 E Chase

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 79995 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 32 D 79999

Hdc 1/16459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No., , ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Spriggs

(a) RESIDENCE NO. 626 McCulloh St. WARD
(Usual place of abode) N Bond Baltimore
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Louise

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 24; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer — Musician
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed OCT 17 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Oct 15, 1923, that I last saw h alive on Oct 15, 1923, and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows:
Brain tumor (tuberculoma?)

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept. 18-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological

(Signed) Warfield M Theo, M. D.

10/15, 19 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem — DATE OF BURIAL: 10/18 1923

20 UNDERTAKER: Jas. W. Elkins — ADDRESS: 1620 E. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 440 St Mary ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald Ridgely

(a) RESIDENCE NO. 440 St Mary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Elsie Ridgely

6 DATE OF BIRTH (month, day, and year): Oct 11 1901

7 AGE — Years: 22 — Months: 0 — Days: 4 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Simon Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Priscilla Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md

14 Informant: Robert Ridgely

(Address): 639 George St

15 Filed OCT 17 1923 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6th, 1923. to Oct. 15th, 1923. that I last saw h alive on Oct 13th, 1923, and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ethe, M. D.

10/16, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: John H. Owens — ADDRESS: 538 Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state ... supply. ... A PERMANENT RECORD. Every item of infor...

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonorrheal Rheumatism

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80001

CERTIFICATE OF DEATH.

113 D 80001

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1011 N. Fulton Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Elizabeth Lemmon

(a) Residence No. 1011 N. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 19th, 1922

7-AGE. 1 yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clayton I. Lemmon

11-BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Cogswell

13-BIRTHPLACE OF MOTHER (city or town) Lebanon (State or Country), Indiana

14. (Informant) C. I. Lemmon

(Address) 1011 N. Fulton Ave

15. OCT 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 16th, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Oct. 16, 1923 that I last saw her alive on Oct. 16 1923 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute gastro-enteritis

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hamm C. Todd M. D.

10/17 1923 (Address) 735 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Oct 18th, 1923
20-UNDERTAKER.	ADDRESS
Strand & Poe	173 N. Fulton Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80002

D 80002

CERTIFICATE OF DEATH.

185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

2-FULL NAME Peter Demberger

(a) RESIDENCE NO 1044 Gramby St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 45 to 50				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Eastern Police Station
(Address)

15 Filed OCT 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture d Skull- Fell down stairs
Accidental
(Reported to have been intoxicated)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Owens, M. D.
(Coroner.)

10/16/23, 192 (Address) 508 E. N orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health,
body not claimed

Every item of information must be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D-80003 HEALTH DEPARTMENT—CITY OF BALTIMORE

X185-D-80003

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hosp. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Eckman

(Residence in Baltimore: No. Whitehall, Md St.; yrs.. mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. unknown
(Month) (Day) (Year)

7-AGE. about 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). Germa.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. W. Holden

(Address) Delta, Pa.

15- Filed Oct 17 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct. 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of 4th cervical vertebra. (Fell from apple tree)

(accidental) (Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Oct. 16 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death.... yrs. ....mos.... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Tabernacle Cem Harford Co. Md. DATE OF BURIAL. Oct. 22 1923

20-UNDERTAKER. Wm. J. Tickner & Sons ADDRESS York Pa

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 80004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80004

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Duncan ST., 1 WARD)

2-FULL NAME Mary Reinhardt

(a) RESIDENCE NO. 417 S. Duncan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Albert Reinhardt

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fallwasser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Dr Rutledge

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Oct 14, 1923,

that I last saw h alive on Oct 14, 1923,

and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis arteriosclerosis & mitral regurgitation

(duration) yrs. 1 mos 15? ds.

CONTRIBUTORY (Secondary) Heart failure & asthenia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms.

(Signed) [illegible], M. D.

, 19 (Address) 1623 E. [illegible] Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Htly, Redeemer

DATE OF BURIAL Oct 18 1923.

20 UNDERTAKER Windell Hippert & Son

ADDRESS 37 S. Summit St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 80005 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80005

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST., 19 WARD)

2-FULL NAME Mary E Harvey

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: W C

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Alex J Coates Md

15 1964 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Oct 16, 1923, that I last saw h alive on Oct 15, 1923 and that death occurred, on the date stated above, at 6 25 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Intest. Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T Woodward, M. D.

19 (Address) 1737 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: Oct. 18 1923

20 UNDERTAKER: Geo. J. Smith — ADDRESS: Wallbrook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 17 1923 Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 80006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 80006

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2133 Homewood Ave, ST., 9 WARD)

2-FULL NAME Rose Cecilia Batchelor

(a) RESIDENCE NO. 2133 Homewood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter S. Batchelor

6 DATE OF BIRTH (month, day, and year) Unknown- 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	#	#	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Geogianna Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant J. Carroll Daily
(Address) 2133 Homewood Ave.

15 Filed ..... 19 ..... Registrar Robert P. Harrison,
Burial Permit Clerk.

FL 71923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1923 to Oct 15 1923.
that I last saw her alive on Oct 15 1923,
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Kenlon, M. D.

(Address) 709 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/18/23
20 UNDERTAKER	ADDRESS
C.F.Evans & Son	118 W. Mt.Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80007. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D 80007.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Last Savage

(a) RESIDENCE NO. 107 Winter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Tom Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nancy Hagett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Municipal Hospital Records.

(Address) Robert P. Harrison, Johns Hopkins Hospital

15 Filed OCT 7 1923, 19 Burial Permit C... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 5, 1923 to October 14, 1923, that I last saw him alive on October 13, 1923, and that death occurred, on the date stated above, at 2:50 A.M. The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab & Autopsy

(Signed) Claude A Rose, M. D.

10-15 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

D 80008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Mrs Fannie Kirkwood

(a) RESIDENCE NO. Madisonville Kentucky ST. WARD Madisonville Ky.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl. 17-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Amos Dawett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Lucy Nisbet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant (Address) Mrs Nan Beard, Kentucky

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to Oct 17, 1923.

that I last saw h alive on Oct 17, 1923,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Cayetano Paredes, M. D.

, 19 (Address) Church Home Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madisonville Kentucky DATE OF BURIAL 10/20/23

20 UNDERTAKER H E Hughes ADDRESS 1st & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80009

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Dorris

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed , 19 Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 18, 19 22, to October 14, 19 23,

that I last saw her alive on October 14, 19 23,

and that death occurred, on the date stated above, at 10:20 P. M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronco-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude J. Pearce, M. D.

10-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct. 18 1923
UNDERTAKER Robert J. Pearce & Son Per J. Pearce.	ADDRESS 901 Holbrook St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80010

CERTIFICATE OF DEATH.

46

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3541 Roland Ave ST., 13 WARD)

2-FULL NAME Lennie Taylor

(a) RESIDENCE NO. 3541 Roland Ave ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 Cyrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew C. Taylor

6 DATE OF BIRTH (month, day, and year): Nov. 9-1860.

7 AGE: Years 62 | Months 11 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Andrew C. Taylor 3541 Roland Ave

15 Filed OCT 7 1923, 19 ROBERT E. LAZENBY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Oct 16, 1923,

that I last saw h[illegible] alive on Oct. 16, 1923,

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus & Sigmoid Flexure

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1922

Was there an autopsy? No Laboratory Microscopic

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 17 1923, (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's, Pimlico — DATE OF BURIAL: Oct 19 1923

20 UNDERTAKER: Forace A. Burgee — ADDRESS: 3 [illegible] Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80011 113 D 80011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 713½ W. Saratoga St. ST., H WARD)

2-FULL NAME Nina May Burns

(a) RESIDENCE NO. 713½ W. Saratoga St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 6-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ella Trickle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Frank Burns
(Address) 713½ W. Saratoga St

15 Filed 1 1923 . 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Justs Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Simpson, M. D. (Coroner.)

10-17, 192 (Address) 117 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Oct 18 1923

20 UNDERTAKER Mrs. Mrs J. W. Jenkins — ADDRESS 801 W. Fayette St

IMPORTANT—This CERTIFICATE is a PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state DISEASE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80012 X 90 D 80012

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3633 Chestnut Ave (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elrissa Grant

(a) RESIDENCE. No. 3633 Chestnut Ave WARD.

(Usual place of abode) (If nonresident give city or town and State) California

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rhodes Grant

6 DATE OF BIRTH (month, day, and year) May 6 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Winebora

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ann Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas Firth

(Address) 3633 Chestnut Ave

15 Filed ..... 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1923, to Oct. 17, 1923,

that I last saw h.. alive on Oct. 17, 1923,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. H. Machin, M. D.

19 (Address) 4037 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Front Royal Va	Oct 18 1923

20 UNDERTAKER C. GENOWETH & SON, ADDRESS 3617 CHESTNUT AVE

1923 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80013 HEALTH DEPARTMENT—CITY OF BALTIMORE, D 80013

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2823 Huntington Ave 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward O.F. Fuchs

(a) RESIDENCE. NO. 2823 Huntington Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE Johanna Fuchs

6 DATE OF BIRTH (month, day, and year) Aug 9

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mr Edward O Fuchs 2823 Huntington

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Oct 17, 1923, that I last saw h[e] alive on Oct 16, 1923, and that death occurred, on the date stated above, at 653 A m.

The CAUSE OF DEATH* was as follows:

(Rheumatism (Arthritis)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia (gradually developing) (duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical exam and symptoms

(Signed) H. S. Howard — M. D.

10.17 1923 (Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Oct 20 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

Robert P. Harrison, Burial Permit Clerk.

CT 171923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80014

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harford Rd Richmond St., 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kamm

(a) RESIDENCE No. Harford Rd Richmond St. Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE: Years 65; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Henry Kamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Brimmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H. Kamm (Address) Harford Rd - Richmond Ave

15 Filed ..... 19 ..... Registrar

T 17923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-1, 1923 to 10-16, 1923, that I last saw him alive on 10-15, 1923, and that death occurred, on the date stated above, at 12 20P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chr Int. Nph

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Y

What test confirmed diagnosis? .....

(Signed) H Franc M. D.

10/17, 1923 (Address) 2939 Mc Elderry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: 10/18 1923

20 UNDERTAKER: Geo. M. Frink & Son

ADDRESS: 811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80015

CERTIFICATE OF DEATH.

14 x 90

D 80015

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1609 Eutaw Place ST., 14 WARD)

2-FULL NAME L. Calvin Facenbaker

(a) RESIDENCE NO. 1609 Eutaw Place ST., ... WARD Westernport Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Facenbaker

6 DATE OF BIRTH (month, day, and year) March, 24, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Cleary Coal Co

9 BIRTHPLACE (city or town) Westernport (State or country) Md

PARENTS

10 NAME OF FATHER JeffFacenbaker

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary Michael

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Lula Facenbaker

(Address) Westernport Md

15 Filed OCT 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13 , 1923 to Oct. 17 , 1923 , that I last saw him alive on Oct. 17, 1923. 19 ....., and that death occurred, on the date stated above, at 8 P. M. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Senile myocarditis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Thaubus M. D.

Oct. 19 23 (Address) 1 E. Randall Sy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piedmont Burial Co W Va

DATE OF BURIAL Oct 18th, 1923

20 UNDERTAKER J Bertram Lee

ADDRESS 1723 W Fayette Ave

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80016

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Emersonian Apts. 6A. ST., 13 WARD)

2-FULL NAME Solomon Frank

(a) RESIDENCE NO. Emersonian Apts. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Frank

6 DATE OF BIRTH (month, day, and year) Jany. 10, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoe

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Frank

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Trühart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Dr. Harry Adler
(Address) 1718 Eutaw Place

15 Filed OCT 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from ,19 00 , to 10/16 ,19 23 ,
that I last saw him alive on Oct 16 ,19 23 ,
and that death occurred, on the date stated above, at 9.45 A.m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Harry Adler, M. D.

, 19 (Address) 1718 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 10/19/1923

20 UNDERTAKER: Darrd Sondheim

ADDRESS: 118-20 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 80017.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80017.

CERTIFICATE OF DEATH.

3/

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 N^th Bradford (WARD)

2-FULL NAME Minnie Biscoe

(a) RESIDENCE NO. 1607 N^th Bradford ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6, 1900

7 AGE Years 23 Months 1 Days If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Biscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Julia Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Julia Biscoe

(Address) 1607 N. Bradford

15 Filed ..... 19 .....

ROBERT H. KRAUSER, Registrar

OCT 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Oct 17, 1923

that I last saw her alive on Oct 16, 1923

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) D. I. Lemon, M. D.

Oct 18 1923 (Address) 1301 N Rat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 20 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E 1st

INSTRUCTIONS

This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80018

CERTIFICATE OF DEATH.

13 D 80018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 N. Green ST., 17 WARD)

2-FULL NAME Pietro Tringala

(a) RESIDENCE NO. 311 N. Green ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 16. 1922

7 AGE: Years X Months 11 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Luciano Tringala

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Colmento

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Luciano Tringala 311 N. Green St.

15 Filed , 19 ROBT. H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923, to Oct 17, 1923, that I last saw h alive on Oct 17, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Campbell M. D.

Oct 17 1923 (Address) 1614 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 10/19 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 mks.

D 80019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80019

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1537 Aisquith ST., 9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Tragesser

(a) RESIDENCE NO. 1537 Aisquith ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced.
HUSBAND of (or) WIFE of George Tragesser

6 DATE OF BIRTH (month, day, and year) 9 1 1854

7 AGE: Years 69 Months Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm Sommers
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Rose Hubbel
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Tragesser
(Address) 1537 Aisquith St

15 Filed OCT 18 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Oct. 15, 1923, that I last saw h alive on Oct. 15, 1923, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver

(duration) yrs. 3 mos 15 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of None
Was there an autopsy? No
What test confirmed diagnosis? None.

(Signed) E. Pell Magruder M. D.
10, 17, 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 10/20/1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16689 D 80020

86-001 D 80020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., 76 WARD)

2-FULL NAME Edward Schorr

(a) RESIDENCE No. 1300 S. First ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel Schorr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Milk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel Schorr (Address) 1300 S. First St

15 (Filed) OCT 18 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1923. to Oct 16, 1923, that I last saw him alive on Oct 16, 1923, and that death occurred, on the date stated above, at 4:00 A.m.

The CAUSE OF DEATH* was as follows:

Acute Otitis Media

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Myringotomy

(Signed) H. H. Mead M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cemetery — DATE OF BURIAL Oct 18 1923

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80021

D 80021

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1b.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 1 WARD)

2-FULL NAME Anna Snyder

(a) RESIDENCE No. 151 S Ellwood ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Snyder.

6 DATE OF BIRTH (month, day, and year): Oct. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Fritz Knoche.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lautt Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Snyder (Address): 151 S Ellwood ave.

15 Filed OCT 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage in Pericardium

(duration) yrs. mos. ds.

(Signed) W K Swarbrick, M. D. (Coroner.)

10-15, 1923 (Address) 117 N. Sarato St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Oct. 18 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Mo[illegible]

Remarks Chr. Bright's Disease for several yrs.
History from Hospital

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Cor.—1-12-23—M&T—100 Bks.

80022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 1 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew T. White

(a) RESIDENCE NO 217 S. Chester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie White

6 DATE OF BIRTH (month, day, and year) OCT 6/1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	--	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer General

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Murdock
(Address) 217 S. Chester St.

15 Filed OCT 18 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia - Accidental burns over chest, neck, lt face & head.

(Fell from chair while asleep & clothing caught fire from stove) (duration) ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. McCann, M. D. (Coroner.)

10/18/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patrick's — DATE OF BURIAL Oct 19th 1923

20 UNDERTAKER Lilly & Feeley — ADDRESS 403 S Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 80023 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Walnut St. 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Miller

(a) RESIDENCE. No. 507 Walnut St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexia Miller

6 DATE OF BIRTH (month, day, and year): Oct 12-1873

7 AGE: Years 50 Months — Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Chas Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Florida

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Oct 19-1843

14 Informant (Address): Alexia Miller 507 Walnut

15 Filed OCT 18 1923 Registrar

ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1923, to Oct 17, 1923, that I last saw him alive on Oct 15, 1923 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Regular

(Signed) F. L. Clark, M. D.

(Address) North Ave & Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: Mrs. Chas. B. Jones ADDRESS: 1725 Eastland Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 80024

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-09 80024

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Mount ST., 16 WARD)

2-FULL NAME Infant of Arthur & Marion Brown

(a) RESIDENCE NO. 115 Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None Child
(b) General nature of industry, business, or establishment in which employed (or employer): 00
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Arthur Brown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Marion Hunsky
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14
Informant: Arthur Brown
(Address) 115 N. Mount St

15
Filed OCT 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18 19 23

17
I HEREBY CERTIFY, That I attended deceased from 10/12 .19 23. to 10/18 .19 23.
that I last saw h alive on 10/17 .19 23.
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:
Premature Birth — (7 mo child)
Exhaustion
Respond for all Septic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Benj Rolette, M. D.
, 19 (Address) 1 W Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem
DATE OF BURIAL: OCT 18 1923

20 UNDERTAKER: George I. A. Gibson
ADDRESS 1735 Druid Hill Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80025

CERTIFICATE OF DEATH.

90 D 80025

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 E. Balto. St. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob ~~Barsten~~ Barstein

(a) RESIDENCE No 2300 Hillsdale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	mardied

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Liza Barsten

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retail
(b) General nature of industry, business, or establishment in which employed (or employer) Confectioner
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unk nown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

Reported (duration) at least one yr. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] (Coroner), M. D.

10/17/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lev. Friendship	Oct. 18 1923
20 UNDERTAKER Jack Lewis,	ADDRESS 1439 E. Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80026

CERTIFICATE OF DEATH.

74-006 D 80026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 W Lexington ST., 4 WARD)

2-FULL NAME Samuel M. Tucker

(a) RESIDENCE NO. 623 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred W yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Tucker

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store-keeper 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1439 E. Baltimore St.

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

OCT 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Oct 18, 1923.

that I last saw him alive on Oct 17, 1923.

and that death occurred, on the date stated above, at 7 00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Right hemiplegia)

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

Dyspnoea (duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Oct 18, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cemetery — DATE OF BURIAL Oct 18 1923

20 UNDERTAKER Fact Lewis, 1439 E. Balto — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80027

168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1219 N. Eden St. ST., 10 WARD)

2-FULL NAME Sarah Karlinsky

(a) RESIDENCE NO 1219 N. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: AAron Karlinsky

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Silberman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rissia

12 MAIDEN NAME OF MOTHER: Leah --------

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address): 1438 E. Balto. Md.

15 Filed OCT 18 1923 ROBERT N. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation- Suicide - Hung herself by rope to bed post.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Oliver, M. D. (Coroner.)

10/18/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lev. Harrig Run — DATE OF BURIAL: Oct 18 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1438 E. Balto

Cor.—1-12-23—M&T—100 Bks.

D 80028 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80028

18-006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1st Ave & 12th St., E. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Hopkins

(a) RESIDENCE No. 1711 N. Dallas St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~14~~	15	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Geo. Long Construction Co

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Harrison Hopkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Hemsley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Robt A. Elliott
(Address) 506 Rogers ave

15 Filed OCT 18 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage —
Fractured Ribs R Side —
Lung punctured
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Said Bank Caved in & died on Way
(duration) yrs. mos. ds.
(Signed) Geo. C. Keenan, M. D.
(Coroner)
Oct 18th, 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Odt — DATE OF BURIAL 18th 1923

20 UNDERTAKER Mrs. Robt. A. Elliott — ADDRESS 1727 Edmondson ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80029

CERTIFICATE OF DEATH.

188-D 80029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1345 N. Carey St. ST. 15 WARD)

2-FULL NAME Susie Riley

(a) RESIDENCE NO. 1345 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Beal Elliott
(Address) 1628 Druid Hill Ave

15 Filed Oct. 18, 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Lt. Femur
(automobile accident)
(duration) yrs. 6 mos. 12 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 4 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)
Oct. 17, 1923 (Address) 238 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL M.A. Stein

DATE OF BURIAL Oct. 18 1923

20 UNDERTAKER James R. Lewis

ADDRESS 1313 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 80030 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80030

CERTIFICATE OF DEATH.

15-38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Pratman ST.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Billups.

(Residence in Baltimore: No. 1519 Pratman St. St.; 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	Col.	Married

6-DATE OF BIRTH, Oct 29, 1876
(Month) (Day) (Year)

7-AGE, 46 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Kanuth Billups

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Susan E. Perry

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. B. Billups

(Address) 519 Pratman St

15-

Filed Oct 18 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1923, to Oct 16 1923, that I saw him alive on Oct 14 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Indigestion

(Duration) yrs. 1 mos. ds.

(Signed) James W. Hagar M. D.

Oct 18, 1923, 191 (Address) 513 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Moriah DATE OF BURIAL, Oct 19, 191

20-UNDERTAKER James H. Keene ADDRESS 302 Pratman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Probably Lingular

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis*,	*Childbirth*,	*Convulsions*,
Hæmorrhage,	*Gastritis*,	*Erysipelas*,	*Meningitis*,
Gangrene,	*Miscarriage*,	*Necrosis*,	*Peritonitis*,
Phlebitis,	*Pyæmia*,	*Septicæmia*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

D 80031

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 80031

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 65-4W Mulberry ST., 17 WARD)

2-FULL NAME William Cook

(a) RESIDENCE NO. 65-4W Mulberry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Aug. 11, 1922

7 AGE — Years: 1 — Months: 2 — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Walter Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Edna Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Edna Bowman 65 W. Mulberry St.

15 Filed OCT 18 1923 Registrar

ROBERT [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct-14 1923 to Oct-17 1923.

that I last saw him alive on Oct 16 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diag.

(Signed) R B Stenson M. D.

10/17 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn cemetery — DATE OF BURIAL: Oct 19 1923

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.--400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80032

CERTIFICATE OF DEATH.

31 D 80032

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Malone

(a) Residence No. 528 N. pine st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886?

7-AGE. 37? yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: John Malone

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Polly Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

11- (Informant) Hospital Records

(Address) M.T.H.

Filed OCT 18 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 7 1923 to Oct. 14 1923

(that I last saw h. or alive on Oct. 14 1923

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lallier M. D.

10-15 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 18 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

318

0804

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80033

CERTIFICATE OF DEATH.

90 D 80033

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Belvedere and Charles St.: 15 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Hughes

(Residence in Baltimore: No. 2825 Bernard St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor.
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Peter Hughes

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary ——

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celia Hughes

(Address) 2825 Bernard St.

15-

Filed OCT 18 1923, 191.. ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest (autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Arteriosclerosis of Heart
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Mountain M. D.
(Coroner.)

Oct 18 1923 (Address) 763 Reed

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Towson	Oct 19 1923
20-UNDERTAKER C A Wiedefeld & Son	ADDRESS 501 E 22 St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80034

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 McHenry ST., 19 WARD)

2-FULL NAME Ida May Barth

(a) RESIDENCE NO. 1406 W. McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 30" 1923.

7 AGE — Years: — Months: 1 — Days: 17 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Arthur Barth.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Virginia Cooper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Arthur Barth.

(Address) 1406 McHenry St.

15 Filed OCT 18 1923, 19 — ROBERT R. KRAUTER, Burial Permit Clerk — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/17/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/16/1923, to 10/17/1923.

that I last saw h[illegible] alive on 10/16/1923,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert A Dramm M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Oct 19" 1923

20 UNDERTAKER: George L. Schnat. Frederick Ave. — ADDRESS 2101

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80035

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 80035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE; (No. 3211 O'Donnell St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Ashton

(a) Residence No. 3211 O'Donnell St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. - mos. - ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ashton

6-DATE OF BIRTH (month, day and year) Jan. 1-1855

7-AGE. 68 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 030

(c) Name of employer. Chesapeake Paper Board Co.

9-BIRTHPLACE (city or town)..... (State or Country). England.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). not known

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). not known

14-(Informant) Mrs. M. Noon.

(Address) 3211 O'Donnell St

15-Filed OCT 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 17-1923.

17-I HEREBY CERTIFY, That I attended deceased from June 1923 to Oct - 17 1923 that I last saw h[illegible] alive on Oct - 17 1923, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis,

" Nephritis

(Duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemaplegia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J. Davidson M. D

, 19 (Address) 3035 Aldonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Oct. 20.... 1923

20-UNDERTAKER, Zirkler & Zirkler ADDRESS 1739 E. Eager St.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 80036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80036

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1813 - N. Chester ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. A. Mullen

(a) RESIDENCE. NO. 1813 - N. Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, Widowed, or divorced HUSBAND of (or WIFE of): Mark Hallen Mullen

6 DATE OF BIRTH (month, day, and year): 2/15/1861

7 AGE: Years 6 | Months 8 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Jim Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Elizabeth Tully (Address) 1833 N. Chester St.

15 Filed . 19 Registrar

OCT 18 1923 Robert P. Harrison, Health Commissioner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to Oct. 17, 1923

that I last saw him alive on Oct. 16, 1923.

and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue; 1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Armstrong M. D.

(Address) 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 10/19/23

20 UNDERTAKER: C. J. Ruth & Co. ADDRESS: 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 80037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80037

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1669 Darley ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie - B. Albert

(a) RESIDENCE NO. 1669 Darley ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9/11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Albert.

6 DATE OF BIRTH (month, day, and year) 9/14/99

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	24	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Vincent Stadtler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie Bridel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Henry Albert. 1669 Darley ave.

15 Filed OCT 18 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to 10-17, 1923

that I last saw h alive on 10-16, 1923

and that death occurred, on the date stated above, at 11:30 Am

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Femur — Carcinoma of

Liver (Secondary)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) J. J. Ruth, M. D.

10-17, 1923 (Address) 800 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery — DATE OF BURIAL Oct. 20 1923

20 UNDERTAKER George - J. Ruth — ADDRESS 1735 Harford ave.

Cor.—1-12-23—M&T—100 Bks.

D 80038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80038

155

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 3 WARD)

2-FULL NAME Charles Johnson

(a) RESIDENCE NO 407 S. Dallas St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 1/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Canning Factory

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lucy Smith
(Address) 407 S. Dallas St.

15 Filed OCT 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis of left shoulder. (also small sinus over rt. clavic le)

(Duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Probably bilateral Psoas abcess (Duration) ..... yrs. mos. 21 ds.

(Signed) J. S. Gamm, M. D.
(Coroner.)

10/18/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn C	Oct 19 192
20 UNDERTAKER L. H. Brown & Son	ADDRESS [illegible]

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80039

CERTIFICATE OF DEATH.

92 D 80039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Poplar Grove ST., 16 WARD)

2-FULL NAME Mrs Elizabeth Benty

(a) RESIDENCE NO. 1125 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Benty

6 DATE OF BIRTH (month, day, and year) Dec 14th 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
65 yrs	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margret Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Benty (Address) 1125 Poplar Grove Av

15 Filed OCT 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1923 to Oct 16 1923, that I last saw her alive on Oct 15 1923, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Sudden death due to Coronary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Jos. H Zierlein M. D.

Oct 17, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 10/19/1923

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

ROBERT B. KRANTZ
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

D 80040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 80040

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Alto ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Reese.

(a) RESIDENCE NO. 3313 Alto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno P Reese

6 DATE OF BIRTH (month, day, and year): Dec 9 1844

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Horatio Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Boswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Walter P Reese

(Address): 3310 Alto ave

15 Filed OCT 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 17, 1923,

that I last saw h[illegible] alive on Oct 16. 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Uge

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Cary, M. D.

, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Oct 19 1923

20 UNDERTAKER: W M Routson

ADDRESS: 223 S 11 St

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80041

D 80041

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 N Carey ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marietta J Fowler

(a) RESIDENCE NO. 538 N Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Fowler

6 DATE OF BIRTH (month, day, and year) Nov 19 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John W Jarboe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mc Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Katherine Fowler

(Address) 535 N Carey St

15 Filed ....., 19 .....

OCT 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 17, 1923, that I last saw her alive on Oct 17, 1923, and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James L Gundry M. D.

10/18/23 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Oct 19 1923

20 UNDERTAKER V M Routson

ADDRESS 2235 N Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80042

CERTIFICATE OF DEATH.

X 44 D 80042

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 McMechen St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth T. Yerkes

(a) Residence No. 129 McMechen St., Ward Penna

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P Yerkes

6-DATE OF BIRTH (month, day and year) Nov 20 45

7-AGE. 77 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... Worked at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Not K.

14- (Informant) Mrs Louise Bechtel

(Address) 129 McMechen

15- Filed OCT 19 1923 By ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 18 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Oct 18, 1923, that I last saw h[illegible]ive on Oct 8, 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Coma of Stomach

Oct 18

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph P. Hess, M. D.

, 1923 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL, Oct 20, 1923

20-UNDERTAKER. W M Rowton — ADDRESS 2238 N Howard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80043

CERTIFICATE OF DEATH.

12-9 D 80043

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1506 W. Mulberry ST.: 19 WARD)

2-FULL NAME Annie E. Kraemer

(a) RESIDENCE. No. 1506 W. Mulberry ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of: Reinhold Kraemer

6 DATE OF BIRTH (month, day, and year): Aug. 3, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone (cut)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Dingard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Reinhold Kraemer (Address) 1506 Mulberry St

15 Filed OCT 19 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): OCT 17 1923

17

I HEREBY CERTIFY, That I attended deceased from June 21 . 1920 . to Oct 17 . 1923. that I last saw her alive on Oct 17 . 1923. and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis, Chronic nephritis & ~~Cardiac~~ Rheumatism insufficiency

(duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mennic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Kaufft, M. D.

(Address) 1002 N. Lanvale

OCT 18 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Western

DATE OF BURIAL: OCT 20 1923

20 UNDERTAKER: Geo W. Little

ADDRESS: 2700 EDMONDSON AVE

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80044
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-006

D 80044
REGISTERED NO.

CITY OF BALTIMORE: No 2000 N. Smallwood St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie B. Fritz

(a) RESIDENCE. No. 2000 N. Smallwood ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~
If ~~husband~~ of (or) WIFE of: Daniel J. Fritz

6 DATE OF BIRTH (month, day, and year): Dec 8 1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
71	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

11 Informant (Address): Daniel J. Fritz 2000 Smallwood St

15 Filed . 19 ROBERT R. KRAUTER, Registrar
OCT 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): OCT 18 1923

17
I HEREBY CERTIFY, That I attended deceased from October 14, 1923, to October 18, 1923, that I last saw h[illegible] alive on October 18, 1923, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5- ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia

(duration) yrs. mos. 5- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

Signed: G. W. Billups, M. D.
OCT 19 1923, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: London Park
DATE OF BURIAL: OCT 22 1923, 19

20 UNDERTAKER: Geo W Little
ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 lbs.

D 80045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80045

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Clift.

(a) RESIDENCE NO. 25 Kolb Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nannie G Clift

6 DATE OF BIRTH (month, day, and year) April 5 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soil maker

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Clift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jennie Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Wife Nannie G Clift 25 Kolb Ave

15 Filed OCT 19 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-15-1923, to 10-17-1923,

that I last saw him alive on 10-17-1923, and that death occurred, on the date stated above, at 11½ a m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Interstitial Nephritis

Uremia Coma

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

19 (Address) 715 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Oct 20 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80046 100-901 D 80046

D 80046

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

2-FULL NAME William H. Bowler

(a) RESIDENCE NO. Bay View Hospital. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 10 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records. (Address)

15 Filed OCT 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1923 to October 16, 1923, that I last saw him alive on October 15, 1923 and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude F Jones M. D.

10-16-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Oct 21 1923

20 UNDERTAKER John F Owens — ADDRESS 5-38 Dodd 12E

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80047. HEALTH DEPARTMENT—CITY OF BALTIMORE D 80047.

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 310-N-Fulton ST., 19 WARD)

2-FULL NAME Jacob Johnson

(a) RESIDENCE NO. 310-N-Fulton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Construction work

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Mrs Mamie Jones 310 N. Fulton

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1923, to Oct 18, 1923, that I last saw h[illegible] alive on Oct 17, 1923, and that death occurred, on the date stated above, at 6, 9 m.

The CAUSE OF DEATH* was as follows: Mitral Insuf.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Ch. Interstitial nephritis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Physical

What test confirmed diagnosis? Symptoms, X-ray

(Signed) Walter Jackson, M. D.

, 19 (Address) 64 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — DATE OF BURIAL: Oct 20 1923

20 UNDERTAKER: R. E. Parham — ADDRESS: 902 Leadenhall, St

OCT 19 1923

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80048

CERTIFICATE OF DEATH.

74-001

D 80048

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 E Preston ST., 8 WARD)

2-FULL NAME Louis Kolb

(a) RESIDENCE NO. 1630 E Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Kolb

6 DATE OF BIRTH (month, day, and year): Jan 18 1850

7 AGE: Years 73 | Months 8 | Days 28 | If LESS than 1 day, ... hrs. or .. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brush Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jacob Kolb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Stumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Kolb (Address) 1630 E Preston St

15 Filed OCT 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16 1923

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1923, to October 16, 1923, that I last saw h living on October 16, 1923, and that death occurred, on the date stated above, at 11.25 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Dr Edward Klingenwald, M. D.

10/18 1923 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 19 1923

20 UNDERTAKER: John Ullrich — ADDRESS: 2108 Eden ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 80049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1800 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 76 WARD)

2-FULL NAME Charles Martin East

(a) RESIDENCE NO Furley Ave. & Bowley's Lane WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 15/1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis East

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie Eichorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Louis East
(Address) Furley Ave. & Lowney's Lane

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
OCT 19 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- internal abdomenalinjury- autom bile accident.

(Inquest to be held Oct 18/23

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S A Collins (Coroner.), M. D.

10/18/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 21 1923

20 UNDERTAKER John Ullrich — ADDRESS 2108 Eden

NOTE.—PRINT, WITH PENDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 80050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor Lombard + Greene St., 74 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melton Green

(a) RESIDENCE NO. 1108 Battery Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sophia R. Green

6 DATE OF BIRTH (month, day, and year) Oct 23 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary McVay.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Hospital Records. (Address)

15 Filed OCT 19 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/23 1923 to 10-17 1923, that I last saw him alive on 10-17 1923, and that death occurred, on the date stated above, at 3:10 p. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho Pneumonia

(Duration) yrs. mos. 2. ds.

CONTRIBUTORY (Secondary) Carcinoma of Esophagus

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 9/24/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) James D White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 20 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80051

CERTIFICATE OF DEATH.

74-001

D 80051

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Cambridge St., 1 WARD)

2-FULL NAME Charles Davis

(a) RESIDENCE NO 2116 Cambridge ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3yr yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albertina Davis

6 DATE OF BIRTH (month, day, and year) Apr 9th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albertina Davis
(Address) 2116 Cambridge St

15 Filed OCT 1923 192.....
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day, and year) Oct 17 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy, a stroke

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.
(Coroner)

Oct 18 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Accidental

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt St German	Oct 19 1923
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2060 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

D 80052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80052

CERTIFICATE OF DEATH.

REGISTERED No. C 15 188-003

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp. St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Fink

(Residence in Baltimore: No. 2013 Presbury st St.: 5 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 52 yrs. — mos. — ds. or 5-3 u.T.R., If LESS than 1 day, ...hrs. or....miu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Junk

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Mendle Fink

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Fink

(Address) 2013 Presbury st

15-

Filed ....., 191.... ROBERT B. KRAUTER, Registrar.

OCT 19 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull accidentally Struck by auto

Few hours. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) W. T. Riley M. D.
(Coroner.)

Oct 19, 1923 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rening Fun

DATE OF BURIAL, 10/19, 1923

20-UNDERTAKER, Sol Levinson & Bro

ADDRESS 1127 Balto st

Cor.—1-12-23—M&T—100 Bks.

D 80053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80053

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. East Brooklyn Heights. ST., 25 WARD)

2-FULL NAME Joseph Nowakowski.

(a) RESIDENCE No East Brooklyn Heights. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? 47 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced, WIFE (or HUSBAND) of Mary Nowakowski.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Martin Nowakowski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mary Nowakowski. (wife)

(Address) East Brooklyn Heights.

15 Filed OCT 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Arnhardt, M. D. (Coroner.)

Oct, 18, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Oct. 20th 1923.
20 UNDERTAKER W. F. Sadowski.,	ADDRESS 705 S. Ann St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80054

CERTIFICATE OF DEATH.

129 D 80054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N Monroe ST., 20 WARD)

2-FULL NAME Herman Henry Twelbeck

(a) RESIDENCE NO. 404 N Monroe ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elisa Twelbeck

6 DATE OF BIRTH (month, day, and year) Dec. 16 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Twelbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elise Pierson (Address) 1321 Hanover St.

15 Filed OCT 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16th 1923 to Oct 17th 1923.

that I last saw h[illegible] alive on Oct 16th 1923.

and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Percy O. McCleary, M. D.

10/17 1923 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL Oct. 20 1923

20 UNDERTAKER Mr. & Mrs. John H. Pentz — ADDRESS 851 W. Fayette

ROBERT A. KRAUTER
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

80055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 80055

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 N. North Ave 15 WARD)

2-FULL NAME Mary Plaenker-Horst

(a) RESIDENCE NO. 1841 N. North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of George Horst.

6 DATE OF BIRTH (month, day, and year) Jan 30, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) ~~do~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Anton Schroedner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know. Oct 18. 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Matilda Plaenker (Address) 1841 N. North Ave.

15 Filed OCT 19 1923 19 ..... Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1923, to Oct 18, 1923, that I last saw her alive on Sept 29-Oct 18, 1923, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Flora Fallack, M. D.

(Address) 1112 Center St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Oct. 20 1923.

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80056 ✓ D 80056

D 80056 HEALTH DEPARTMENT—CITY OF BALTIMORE

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 14 S. Schroeder St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Dorothea Harman

(a) Residence No..... 14 S. Schroeder St. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Harman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

11- (Informant) Henry Harman

(Address) 136 S. Schroeder St.

15- Filed OCT 19 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to Oct. 18, 1923, that I last saw h[illegible] alive on Oct. 18, 1923, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia.

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) L. Thos. Corkran, M. D.

10-18 1923 (Address) 838 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Oct 20, 1923

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Park St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80057 HEALTH DEPARTMENT—CITY OF BALTIMORE 160 D 80057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2112 Edmondson Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Nelson Fox

(a) Residence No. 2112 Edmondson Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 14, 1923

7-AGE,	If LESS than 1 day,
....yrs....mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Harry Fox

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Ethel Hoenner.

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Maryland

14- (Informant) Mrs. Matilda Hoenner
(Address) 2112 Edmondson Ave.

15- Filed ..... 192 ..... Registrar.

OCT 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14 1923, to Oct. 18, 1923, that I last saw h.[illegible] alive on Oct. 18, 1923, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Scleroma Neonatorum

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

10-19 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Oct 19 1923
20-UNDERTAKER, Wm P Cook	ADDRESS 1003 N. Bath St

D 80058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-09

D 80058

Registered No. C .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1426 W. Mosher St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Langley Burroughs

(Residence in Baltimore: No. 1426 W. Mosher St.; yrs. .. mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	Single

6-DATE OF BIRTH. Oct. (Month) 16 (Day) 1923 (Year)

7-AGE. yrs. mos. 3 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE. (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Langley Burroughs

11-BIRTHPLACE OF FATHER. (State or Country): Va

12-MAIDEN NAME OF MOTHER: Emma Powell

13-BIRTHPLACE OF MOTHER. (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Langley Burroughs.

(Address) 1426 W. Mosher.

15 Filed OCT 19 1923 16 Robert P. Harrison, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

Oct. 18 1923 (Address) 582 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct 19 1923

20-UNDERTAKER: Sam'l. H. Case & Son — ADDRESS: 1400 Mosher

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

1-8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

16 D 80059 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80059

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... St. 11 Ward)

2-FULL NAME Margaret Garrett

(a) RESIDENCE No. 1119 Park Ave St. ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	9	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Frank Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Pauline Grass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Pauline Garrett 1119 Park Ave

15 Filed ..., 19 ... Registrar Robert P. Harrison, Burial Permit Clerk.

OCT 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1923 to Oct 17, 1923 that I last saw her alive on Oct 17, 1923 and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Dysentery Diarrhoea (not dysentery)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Veech, M. D.

10-18, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and (Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. M. Sloan DATE OF BURIAL Oct 19 1923

20 UNDERTAKER: Sam W. Case Son ADDRESS 1400 Mosher

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80060 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80060

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. London Park Lane ST.; [illegible] WARD)

2-FULL NAME Celia Mitchell

(a) RESIDENCE. NO. London Park Lane WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Mitchell

6 DATE OF BIRTH (month, day, and year) June 6 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Estelle G. Ashby (Address) 777 Edmondson Ave

15 Filed OCT 19 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 16, 1923, that I last saw h[illegible] alive on Oct 16, 1923, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Pulmonary oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David Strauss, M. D.

10/17, 1923 (Address) 4 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 20 1923
20 UNDERTAKER E. W. Dill	ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 80061 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80061

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Dobson

(a) Residence No. 1110 Monument St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Laura A Dobson

6-DATE OF BIRTH (month, day and year): 1864

7-AGE: 59 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS:
10-NAME OF FATHER, George Dobson
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Charlotte Melhorn
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records
(Address)

15- Filed 1923 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 6 1923 to October 18 1923
that I last saw him alive on October 17 1923
and that death occurred, on the date stated above, at 2:30 A.M. P.M.

The CAUSE OF DEATH* was as follows:
Benign prostatic hypertrophy -
Generalized arteriosclerosis -
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Terminal Pneumonia - (Broncho)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes - Date of 8-23-23.
Was there an autopsy? No
What test confirmed diagnosis? Operative & Clinical findings
(Signed) Anthony V. Buchner, M. D
10-18-1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 22nd 1923

20-UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

OCT 19 1923 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80062

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., WARD)

2-FULL NAME Joseph Emerick

(a) RESIDENCE No. 1615 Aliceanna ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Emerick.

6 DATE OF BIRTH (month, day, and year) Feb 15 75

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 678

(b) General nature of industry, business, or establishment in which employed (or employer) U. R. R. Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa. Johnstown Pa.

PARENTS

10 NAME OF FATHER Joseph Emerick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Johnstown Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Nellie Emerick (Address) 1615 N. Aliceanna St

15 Filed OCT 19 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct. 17, 1923; that I last saw him alive on Oct. 17, 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2/27/23.

Was there an autopsy? no.

What test confirmed diagnosis? P. S. & A. + Lab.

(Signed) Harold E. Pelbham M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 20 1923

20 UNDERTAKER George F. Ruth — ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lymph Gland of Neck

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80063 D 80063

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Foot Clinton ST., No WARD)

2-FULL NAME Thomas Jr. Croswell

(a) RESIDENCE NO Reedsville, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Croswell

6 DATE OF BIRTH (month, day, and year) Dec 13th 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Capt - Schooner Elizabeth Ann
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Geo. Croswell

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant C R. Croswell
(Address) 3827 Pen Lucy Heights Ave

Filed OCT 19 1923 192 Registrar.

Burial Permit Given.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

a ond

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Hy. B. Norton, M. D.
(Coroner.)

Oct 19, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reedville Va. DATE OF BURIAL: Oct. 21, 1923 192

20 UNDERTAKER: H. E. Hughes. ADDRESS: 434 N. Broadway.

D 80064 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80064

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 809 N Fremont Ave St. 17 Ward)

Registered No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate S Roehrig

(Residence in Baltimore: No. 809 N Fremont Ave Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: Oct (Month) 6 (Day) 1856 (Year)

7-AGE: 67 yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS:
10-NAME OF FATHER: Jonathan Shakespear
11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md
12-MAIDEN NAME OF MOTHER: Amanda M Crouch
13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Shakespear

(Address) 1029 Light St

15-

Filed OCT 19 1923 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Dated Oct 19 1923 (Address) 280 E Fayette St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Savannah Ga	Oct 19 1923
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80065

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Ashland Ave ST., 10 WARD)

2-FULL NAME Vincenzina Panzarella

(a) RESIDENCE No. 1005 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Angelo Panzarella

6 DATE OF BIRTH (month, day, and year): Aug. 19-1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Mariano Re

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Josephine Corso

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Angelo Panzarella 1005 Ashland ave

15 Filed . 19 Registrar

Robert P. Hart, Sec.

Burial Permit Clerk

OCT 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-18 1923

17

I HEREBY CERTIFY, That I attended deceased from June . 1922 . to 10-18- . 1923

that I last saw h[illegible] alive on 10-18- . 1923

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) 2 yrs. mos dy.

CONTRIBUTORY (Secondary) Pulmonary metastatic Carcinoma (duration) yrs. 6 mos. da

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1922

Was there an autopsy? no

What test confirmed diagnosis? microscopical -

(Signed) S. D'Amato M. D.

. 19 (Address) 160 E Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 10/20/23

20 UNDERTAKER: George J. Roth

ADDRESS: 1735 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Busse)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80066

CERTIFICATE OF DEATH.

91-002

D 80066

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 4505 Maine Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Irving Busse

(a) Residence No. 4505 Maine Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Nov. 30. 1847

7-AGE: 75 yrs. 10 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Catasaqua Pa

PARENTS.

10-NAME OF FATHER: Jacob Busse

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Sarah Steiner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): N. J.

14- (Informant) D. Walter Sparks

(Address) 4505 Maine Ave

15-

Filed 192 Robert P. Harrison Registrar.

OCT 19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 18-23

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1923 to Oct 18 1923

that I last saw him alive on Oct 18 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Aneurism of abdominal Aorta — Rupture

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Surgical

What test confirmed diagnosis? Autopsy

(Signed) A. C. Bunch M. D

Oct 19 1923 (Address) 4309 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Oct. 20 1923

20-UNDERTAKER: Geo. J. Smith — ADDRESS: 1532 Hollins St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80067.

CERTIFICATE OF DEATH.

74-091

D 80067.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 740 W North ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Snader Granger

(Residence in Baltimore: No. 740 W North ave St.; 2 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Aug 2 (Month) (Day), 1858 (Year)

7-AGE, 65 yrs. 2 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Thomas Snader

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Wilhelmina Brain

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard J Muse

(Address) 740 W North Ave

15-

Filed....., 191.....

Registrar.

OCT 19 1917

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Oct 18 1917, that I saw her alive on Oct 17 1917, and that death occurred, on the date stated above, at 3.50 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Exhaustion (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin R Wood M. D.

....., 191... (Address) 2108 Druid Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem

DATE OF BURIAL, Oct 20, 1917

20-UNDERTAKER George J Smith

ADDRESS 532 Hollins st

Spec.—1-10-21—M&T—1500 Bks.

Daniel Gealey

D 80068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80068

CERTIFICATE OF DEATH

118-00

1-PLACE OF DEATH University Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Donald Fealey

(a) RESIDENCE NO. 115 S. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Mrs. Ellen Fealey

6 DATE OF BIRTH (month, day, and year) Unknown 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 621

(c) Name of employer Bro. O. Ireland

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER John Fealey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Annie Carling

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant University Hospital (Address)

15 Filed ..... 19 ..... Registrar

OCT 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1923, to Oct 19, 1923, that I last saw him alive on Oct 19, 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Epigastric & umbilical hernia complicated by bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Sept 16 23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. P. Geller, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rawlings Nat'l Cem.

DATE OF BURIAL Oct 22 1923

20 UNDERTAKER Geo. W. Sons

ADDRESS 901 Hollins St

Geo W Geo W Sons

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80069

D 80069

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2320 Division ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Morris

(a) RESIDENCE NO. 2320 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lora Morris

6 DATE OF BIRTH (month, day, and year) ? 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Samuel Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ruffins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lora Morris

(Address) 2320

15 Filed OCT 20 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1923, to Oct 17, 1923, that I last saw him alive on Oct 17, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

Oct 24, 1923 (Address) 1708 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL. Oct 20 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Division

OCT 20 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80070 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80070

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 700 Clinton ST., Na WARD)

2-FULL NAME John H. Brown

(a) RESIDENCE NO. 3813 Foster Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Martha Brown

6 DATE OF BIRTH (month, day, and year) Apr 18 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cable Splicer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Pa. R.R. - 029

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Overdron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martha Brown
(Address) 3813 Foster Ave

15 Filed OCT 20 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(duration) hrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

Oct 18, 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct. 20 1923
20 UNDERTAKER	ADDRESS
H. Vandever & Sons	1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should stu-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 80071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Warnecker

(a) RESIDENCE No 842 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) April 6/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Warnecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Venker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Anna Warnecker
(Address) 842 S. Linwood Ave

15 Filed OCT 20 1923 Robert P. Harrison, Registrar
[Burial Permit Clerk]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Dysentery (AS yet unidentified, Probably of "Flexner type. Autopsy at hospital

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Wallen, M. D.
(Coroner.)

10/19/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	Oct 20 1923
20 UNDERTAKER	ADDRESS
H. Sanders & Sons	1710 Fleet St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Sponsel)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 80072

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80072

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 N. Regester St.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christ. J. Sponsel

(a) RESIDENCE. NO. 1616 N. Regester St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Christ. J. Sponsel

6 DATE OF BIRTH (month, day, and year) March 30, 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
20	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Bernard Sponsel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mathilda Weinrich

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Christ. J. Sponsel (Address) 1616 N. Regester St.

15 Filed . 19 Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Oct 18, 1923, that I last saw h alive on Oct 17, 1923, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & X-Ray

(Signed) Ernest C. Elmsh, M. D.

Oct 18, 1923 (Address) 4 E. Centre St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Oct 21 1923

20 UNDERTAKER H. Vanderwerken Sons — ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 80073 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80073

CERTIFICATE OF DEATH. 51

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1566 Ridgely St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Wm Clelland

(a) RESIDENCE NO. 1566 Ridgely. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 13 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	10	18	

8 OCCUPATION OF DECEASED at school

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Theodore Wm Clelland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ada Kuyler.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Theodore Wm Clelland

(Address) 1566 Ridgely St

15 Filed ....., 19..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Oct 18, 1923, that I last saw him alive on Oct 18, 1923, and that death occurred, on the date stated above, at 11 40 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Manley Young, M. D.

Oct 19, 1923 (Address) 7 E Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Oct 20, 1923

20 UNDERTAKER John Ullrich

ADDRESS 2008 Allens

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 201923

Cor.—1-12-23—M&T—100 Bks.

D 80074 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80074

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

2-FULL NAME Fred Beel

(a) RESIDENCE NO. Dont Know ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Dont Know

9 BIRTHPLACE (city or town) (State or country) " " "

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs
(Address)

15 Filed ..... 192 .....
Registrar

OCT 20 1923

Fred Beel, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W. H. Grunert, M. D.
(Coroner.)

10-19 . 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-20 1923
20 UNDERTAKER	ADDRESS
Dennis Easter	916 Gaines

Filed Oct 20 1923 Robert F. Garrison, Register of Wills Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80075

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) ST., 14 WARD)

2-FULL NAME James Evans

(a) RESIDENCE No. 711 Lamons ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 4-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	—	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John Hopkins Hosp (Address) [illegible] Lanvale St

15 Filed , 19 Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1923, to Oct 18, 1923, that I last saw h[illegible] alive on Oct 18, 1923 and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital syphilis

(duration) yrs. Life mos 3 ds. +

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Wassermann

(Signed) H. H. Wiech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 10-20 1923

20 UNDERTAKER Daniel Earlom — ADDRESS 916 Lemmon

Burial Permit Clerk.

WARNING—RESERVED FOR OFFICIAL PURPOSES

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80076
16999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D 80076

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vallie Coulson

(a) RESIDENCE NO. Morgantown. W. Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of James Coulson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	22	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Albert Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Hattie Goodwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant James Coulson (Address) Morgantown W. Va

15 Filed . 19 Robert P. Harlan, Registrar

OCT 20 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923 to Oct 19, 1923,

that I last saw her alive on Oct 19, 1923

and that death occurred, on the date stated above, at 4 20/8 m.

The CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage with gangrene of small gut.

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) perforation of bowel + peritonitis

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 19. 23.

Was there an autopsy? no

What test confirmed diagnosis? operation, exploratory

(Signed) Vincent Vermooten, M. D.

, 19 (Address) Johns Hop. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W Va

DATE OF BURIAL: Oct 20 1923

20 UNDERTAKER: Henry W. Jenkins Sons & Co

ADDRESS: Orchard Inc Cullod

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Nephritis

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80077 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80077

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 602 S. Kenwood ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cerulla

(a) Residence No. 602 S. Kenwood ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 27-1884

7-AGE. 39 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Fred. Cerulla

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

14- (Informant) Anna M. Schehlein

(Address) 602 S. Kenwood ave

15- Filed OCT 20 1923 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 19-1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4 1923 to Oct 18 1923, that I last saw h. alive on Oct 18 1923, and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Toxemia (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted? If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Examination

10/19, 1923 (Signed) [illegible] M. D (Address) 301 S. Ellwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oaklawn	Oct 23, 1923

20-UNDERTAKER. Zirkler + Zirkler ADDRESS Eager

Robert P. Harrison, Registrar

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80078 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80078

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3320 Gwynn Oak Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Wright

(a) Residence No. 3320 Gwynn Oak Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 20 1923

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John L Wright

6-DATE OF BIRTH (month, day and year) March 13, 1841

7-AGE. 82 yrs. 7 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. Thomas Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER. Nancy Talbot

13-BIRTHPLACE OF MOTHER (city or town) Talbot Co (State or Country), Maryland

11- (Informant) Mrs. Gertrude Wright Duncan

(Address) 3320 Gwynn Oak Ave

15- Filed OCT 20 1923 Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 19 1923

17- I HEREBY CERTIFY, That I attended deceased from July 7 1923 to Oct 19 1923

That I last saw her alive on Oct 17 1923

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

Cerebral Arteriosclerosis

About 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General arterio-sclerosis

(Duration) Many yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lovard M. D

Oct 20 1923 (Address) 4 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL. Oct 22 1923

20-UNDERTAKER. George D Smith

ADDRESS 1532 Hollins

Cor.—1-12-23—M&T—100 Bks.

D 80079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Pier 5 Locust St., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Pierson

(a) RESIDENCE NO. Steamship Nebraska lying at Pier 5 Locust St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	76	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dep't. (Address) Eastern Dist

15 Filed ..... 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 20 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fell overboard

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis Kerdon, M. D. (Coroner.)

Oct 20, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Oct 20 1923

20 UNDERTAKER Sol. Levin & Bro — ADDRESS 1177 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80080

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80080

100-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Rondo.

(a) RESIDENCE NO. 166 N. Exeter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/3/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39.	—	19	— / —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER John Rondo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Maria Rondo

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Rose Rondo
(Address) 166 N. Exeter St

15 Filed . 19 Registrar

Robert P. Harrison,
Burial Permit Clerk.

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/23

17 I HEREBY CERTIFY, That I attended deceased from October 13. 1923. to October 19 1923.

that I last saw h— alive on Oct. 9 1923.

and that death occurred, on the date stated above, at 1.50 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Schumacher M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent's Cemetery

DATE OF BURIAL 10/20/23

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-B 80081

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N. Milton Ave. WARD) 6

2-FULL NAME Margaret Weaver.

(a) RESIDENCE NO. 136 N. Milton Ave. WARD 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Weaver.

6 DATE OF BIRTH (month, day, and year) May 4th 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Schuppel.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Rose Reachuttler.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant (Address) John J. Weaver. 136 N. Milton ave.

15 Filed ..... 19 ..... Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6 , 1923 , to Oct 18 , 1923 ,

that I last saw her alive on Oct. 17 , 1923 ,

and that death occurred, on the date stated above, at 2-25 a m.

The CAUSE OF DEATH* was as follows:

Paralysis R Side

(duration) 6 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Examination

(Signed) Geo Clinton Blades, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gall. Lawn—Essex.	Oct. 20th 1923
20 UNDERTAKER Lilly & Geier	ADDRESS 4033 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will bo sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec. 1-10-21 M&T 1500 Blks.

D 80082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80082

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Brookfield Ave. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Erlanger

(a) RESIDENCE NO. 2201 Brookfield Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Shoe

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Deals Island Md.

PARENTS

10 NAME OF FATHER: Max Erlanger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Bachrach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Rose Goldman

(Address) 2201 ~~Brookfield~~ Ave.

15 Filed ..., 19 ... Registrar

OCT 20 1923

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/23. 19

17 I HEREBY CERTIFY, That I attended deceased from October 11, 19 23, to Oct 18, 19 23, that I last saw him alive on October 18, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 30 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac R. Adelberg, M. D.

Oct 19, 1923 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	10/21/23
20 UNDERTAKER	ADDRESS
Darrd Sondheim	1102 W. Pro. ext. Royal Ave.

Cor.—1-12-23—M&T—100 Blks.

(Battle)

D 80083 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80083
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Linden Ave ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosella Batts

(a) RESIDENCE No 912 Linden Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Batts

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.,

12 MAIDEN NAME OF MOTHER Annie Hines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.,

14 Informant John Batts
(Address) 912 Linden ave.

15 Filed OCT 20 1923, 192
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

whooping cough.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) yrs. mos. 2 ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Oct. 19 1923 (Address) 2707 Eastlander Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 20 192 3

20 UNDERTAKER Frank Hinsley

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 20 1923
Bureau of Vital Statistics

Spec.—1-10-21—M&T—1500 Bks.

D 80084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80084

CERTIFICATE OF DEATH.

164

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Spurry

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE: Years 90 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed OCT 20 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 23

17

I HEREBY CERTIFY, That I attended deceased from September 19 17. to October 18. 19 23.

that I last saw her alive on October 17, 19 23,

and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Hanna M. D.

10-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health. OCT 20 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. / WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Veney

(a) RESIDENCE NO. 2304 McCullough St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	?

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address) Robert B. Harrison,

15 Filed , 19 Burial Permit Clerk Registrar

1-12-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from October 15, 1923, to October 16, 1923,

that I last saw her alive on October 16, 1923,

and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis (Hegurgitation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G Hamm, M. D.

10-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Minkins

D 80086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80086

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500½ Bakr. ST. 14 WARD)

2-FULL NAME Walter Minkins

(a) RESIDENCE NO. 500½ Bakr ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 46 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Murdered.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Albert Minkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Annie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Edna Talbot

(Address) 1733 Druid Hill Ave

15 Filed OCT 20 1923, 19 ..... Registrar

Robert E. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/17, 1923, to 10/18, 1923, that I last saw h[illegible] alive on 10/18 1923, and that death occurred, on the date stated above, at 10[illegible] m.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

~~Cardiac~~

Aortic incompetency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhart, M. D.

10/19 1923 (Address) 213 Dr Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn. DATE OF BURIAL 10/21 1923

20 UNDERTAKER James N. Dennis ADDRESS 1303 Druid Hill Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80087

CERTIFICATE OF DEATH.

74-001 D 80087

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 Bruce (W) ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Collins

(a) RESIDENCE NO. 1554 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Isabel Collins

6 DATE OF BIRTH (month, day, and year) Sept. 15- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 -	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture mover

(b) General nature of industry, business, or establishment in which employed (or employer) Hauling furniture

(c) Name of employer Kaufman & Co.

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Chas Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Carrie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Lola Collins

(Address) 1554 N. Bruce St.

15 Filed , 19 Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 11 - , 1923, to Oct. 17 - , 1923, that I last saw him alive on Oct. 17 - , 1923, and that death occurred, on the date stated above, at 11-47 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) - yrs. - mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Ellis Corbett M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/22 1923
20 UNDERTAKER James A. Dennis	ADDRESS 1213 Edmondson

Spec.—1-10-21—M&T—1500 Bks.

D 80088 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80088

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1360 N. Stricker ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anderson Jackson

(a) RESIDENCE NO. 1360 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept. 27th 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	✓	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Pearl Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Peter Jackson (Address) 1360 N. Stricker St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17th, 1923, to Oct. 18th 1923, that I last saw him alive on October 17th, 1923 and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Intoxication.

.....(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) .....

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis H. Douglass, M. D.

10-19-1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 10/20 1923

20 UNDERTAKER James H. Dennis

ADDRESS 303 Gilmor

Robert F. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 80089

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 E. Decker Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles . Czekalski

(a) RESIDENCE NO. 1222 E. Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Stanislaus Czekalski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Ida Czechowski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mr Stanislaus . Czekalski (Address) 1222 E. Decker Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 , 19 23 , to Oct 19 , 19 23 ,

that I last saw h alive on Oct 18 , 19 23

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Empyema

Status Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Samuel A Fisher , M. D.

, 19 (Address) 3126 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Oct 22 1923

20 UNDERTAKER John M Weber ADDRESS 803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

D 80090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80090

160

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S Montford ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph McCanna

(a) RESIDENCE No. 520 S Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12 1923

7 AGE — Years: — Months: 7 Days: 6 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Joseph McCanna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Florida Florida

12 MAIDEN NAME OF MOTHER: Antonia Tomeka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant (Address): Joseph McCanna 520 S Montford

15 Filed , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 19 23

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923, to Oct 19, 1923, that I last saw him alive on Oct 18, 1923 and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

Following Intention

(duration) , yrs. mos ds.

CONTRIBUTORY (Secondary) Enamitian

(duration) yrs 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Daniel S Fisher, M. D.

, 19 (Address) 332 S Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Oct 20 1923

20 UNDERTAKER: John H Weber — ADDRESS: 1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

D 80091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80091

CERTIFICATE OF DEATH.

45

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Boone ST., 9 WARD)

2-FULL NAME Daisy Rudl Alexander

(a) RESIDENCE NO. 2105 Boone ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stanley R Alexander

6 DATE OF BIRTH (month, day, and year): Oct 4 1877

7 AGE — Years: 46 — Months: 0 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Henry M. Rudl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jane Kirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Louise A Rudl
(Address): 306 E. Fayette St

15 Filed OCT 20 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1923, to Oct 18, 1923, that I last saw her alive on Oct 17, 1923 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Carcinomatosis
Secondary to Carcinoma of rectum. Operated upon
about 1 yrs 7 mos ds.
(duration)

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 1919

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

, 19 (Address) 1100 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 20 23

20 UNDERTAKER: Wm J Ruckert & Sons — ADDRESS: North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 80092 HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 D 80092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 750 W Fayette ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T. Hilleary

(a) RESIDENCE NO. 750 W. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cordelia Hilleary

6 DATE OF BIRTH (month, day, and year) Jan 13. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Henry Hilleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Rebecca Ragen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Reuben L. Kann 750 W. Fayette St

OCT 20 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1923, to Oct 19, 1923, that I last saw him alive on Oct 19, 1923, and that death occurred, on the date stated above, at 7A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

Oct 20 1923 (Address) 2608 Westen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 22 1923

20 UNDERTAKER Mr. & Mrs. John W. Tenfelt & Son — ADDRESS 801 W. Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80093

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N Fulton Ave ST.: 19 WARD)

2-FULL NAME J. Harvey Dennis

(a) RESIDENCE. NO. 115 N. Fulton Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie R. Dennis

6 DATE OF BIRTH (month, day, and year): July 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Hanger & Decorator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Benjamin M. Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Annie M. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Carrie V. Dennis
(Address): 115 N. Fulton Ave

15 Filed . 19 Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1923

17

I HEREBY CERTIFY, That I attended deceased from January 24, 1923, to Oct 19, 1923,

that I last saw h— alive on Oct 18, 1923,

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac oedema and Chronic Parenchymatous nephritis.

(duration) yrs. 7/12 mos. ds.

CONTRIBUTORY (Secondary): Lobar Bronchial pneumonia

(duration) June 1923. yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Durand L Faust, M. D.

(Address) 707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct. 22 1923

20 UNDERTAKER: Mr & Mrs John W. Teufel & Son — ADDRESS: 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80094

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-96 80094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1433 Washington Blvd. ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann. Banks

(a) RESIDENCE. No 1433 Washington Blvd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin F. Banks.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67 yrs.	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Ludlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary Rouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Lillian Thawley

(Address) 1433 Washington Blvd.

15 [illegible] 1923 Registrar

OCT 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1923, to Oct 17, 1923, that I last saw her alive on Oct 17, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Harry [illegible] M. D.

Oct 19 1923 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 20 1923
20 UNDERTAKER Wood B. Cook	ADDRESS Nat. Bk. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 80095 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80095

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 W. Lexington St. St., 18 Ward)

2-FULL NAME Norman P. Huster Jr.

(a) RESIDENCE No. 1215 W. Lexington St. St., Ward .....
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7.	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Norman P. Huster Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Chalmers

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Mrs. Helen Chalmers
(Address) 1215 W. Lexington St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 12, 1923 to October 18, 1923
that I last saw him alive on " " 1923
and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of "

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw. F. Cochran, M. D.

10/19 1923 (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Oct 22 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto

Cor.—1-12-23—M&T—100 Blks.

D 80096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80096

CERTIFICATE OF DEATH.

9

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 W Fayette ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arlem Simmons

(a) RESIDENCE No. 865 W Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work L
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bath City
(State or country)

PARENTS

10 NAME OF FATHER Gardner F Simmons

11 BIRTHPLACE OF FATHER (city or town) Atlanta Ga
(State or country)

12 MAIDEN NAME OF MOTHER Ruby Jones

13 BIRTHPLACE OF MOTHER (city or town) Douglas Mo
(State or country)

14 Informant
(Address) 865 W Fayette St

15 Filed , 192
Registrar

CT 201923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 2 ds.

(Signed) W R Donnel, M. D.
(Coroner.)

Oct 20, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 20 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1000 W Baltimore

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80097

101-001

CERTIFICATE OF DEATH.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 N. Schuter ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Hill

(a) RESIDENCE NO. 910 N Schuter ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE: Years 33 | Months 3 | Days ? | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alex Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katie Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Alex Hill 910 N Schuter

15 Filed OCT 20 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/14/ 1923, to 10/18/ 1923

that I last saw h alive on 10/18/ 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Double.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lewis Bowles M. D.

10/19/ 1923 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Moriah cemetery — DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

D 80098

HEALTH DEPARTMENT—CITY OF BALTIMORE

75-D001 80098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Bailey

(a) RESIDENCE No. 1433 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. E[illegible] item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed , 19 Registrar

OCT 20 1923

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 14, 19 23 to October 17, 19 23, that I last saw her alive on October 17, 19 23, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Right Hemiplegia (Resolved)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (Terminal) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Jones M. D.

10-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	10-21 19 23
20 UNDERTAKER	ADDRESS
Frank Taylor	Oswego

Spec.—1-10-21—M&T—1500 Bks. 80099

HEALTH DEPARTMENT—CITY OF BALTIMORE

16427 D 80099 X 84 D 80099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances T Surber

(a) RESIDENCE NO. 90 Church St, Charleston S C ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13 1923

7 AGE — Years: 0 — Months: 7 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Charleston (State or country) South Carolina

PARENTS

10 NAME OF FATHER Charles Thurber

11 BIRTHPLACE OF FATHER (city or town) Fla (State or country)

12 MAIDEN NAME OF MOTHER Marian Spinner

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Charles Thurber
(Address) Charleston, S.C.

15 Filed OCT 21 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1923 to Oct. 20, 1923, that I last saw her alive on Oct 20, 1923 and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus - internal

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Brain tumor

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? Yes Date of Oct 20-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Exam

(Signed) Warfield M Jeron M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jacksonville Fla.
DATE OF BURIAL: 10/20 19 23

20 UNDERTAKER: H E Hughes
ADDRESS: Hunt St. Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Malignant

Spec.—1-10-21—M&T—1500 Bks. 80100

D 80100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 80100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2818 Boarman Ave WARD 15)

2-FULL NAME James M. Hills

(a) RESIDENCE No. 2818 Boarman Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lomyra Belye Hills

6 DATE OF BIRTH (month, day, and year): June 18, 1845

7 AGE — Years: 78 Months: 2 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Conn.

PARENTS

10 NAME OF FATHER: Oliver S. Hills

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn

12 MAIDEN NAME OF MOTHER: Mary Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn

14 Informant: Bessie Hills Doherty (Address) 2818 Boarman ave

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923, to Oct 20, 1923, that I last saw h living alive on Oct 20 1923, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

Pulmonary Oedema

(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. J. Doherty M. D.

, 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Torrington Conn. DATE OF BURIAL: Oct 21 1923

20 UNDERTAKER: John A Mitchell ADDRESS: 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80101

D 80101

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 448 E Cross ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Walstrum Popwitch.

(a) RESIDENCE No. 448 E Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Popwitch.

6 DATE OF BIRTH (month, day, and year): April 14 189[illegible]

7 AGE — Years: 32 — Months: 6 — Days: 4 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Samuel S. Walstrum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash. D.C.

12 MAIDEN NAME OF MOTHER: Jennie Hilbig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Jennie Walstrum 448 E Cross St

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18. 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1923, to Oct 9, 1923,

that I last saw her alive on Oct 9, 1923,

and that death occurred, on the date stated above, at 1145 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? natural

(Signed) W. L. Smith M. D.

, 1923 (Address) 109 N. Eu Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: 10-23-1923

20 UNDERTAKER: Earl B. Hasle — ADDRESS: 115 E Read St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired. 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis
Cut.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80102

CERTIFICATE OF DEATH.

101-001

D 80102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Clement ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nick. Fichle

(a) RESIDENCE NO. 1409 Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Fichle

6 DATE OF BIRTH (month, day, and year): Feb 16 1864

7 AGE: Years 59 Months 8 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hungary.

PARENTS

10 NAME OF FATHER: John Fichle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary.

14 Informant: Eva Fichle

(Address): 1409 Clement St

15 Filed OCT 21 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1923, to Oct. 18, 1923, that I last saw h— alive on Oct. 18, 1923 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. S. Mayo M. D.

10-18-1923 (Address) 811 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — DATE OF BURIAL: 10-22 1923

20 UNDERTAKER: Chas R Stevens — ADDRESS: Fort Ave & Hull St

Spec.—1-10-21—M&T—1500 Bks.

D 80103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80103

CERTIFICATE OF DEATH.

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (WARD)

2-FULL NAME Mills Lowe

(a) RESIDENCE NO. 1730 gorsuch ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 14 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	31	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER James Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Sarah Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md

14 Informant Lester Lowe

(Address) 1730 Gorsuch Ave

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923, to Oct 20, 1923, that I last saw him alive on Oct 20, 1923, and that death occurred, on the date stated above, at 1:25 p. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.
(Hemorrhagic)

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B. MacGowan, M. D.

10/20/1923 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Good Will Cem Harford Co — DATE OF BURIAL: Oct 21 1923

20 UNDERTAKER: E. H. Kurtz & Son — ADDRESS: Forrestville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 80104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 80104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Lake Montebello Terr. ST., 27 WARD)

2-FULL NAME Julia A. Schuenholz

(a) RESIDENCE No. 2103 Lake Montebello Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Schuenholz, Jr.

6 DATE OF BIRTH (month, day, and year) June 31st 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin Weikert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert R. Schuenholz

(Address) 2103 Lake Montebello Terrace

15 Filed OCT 21 1923 By ROBERT F. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1922 to October 19, 1923.

that I last saw her alive on October 18, 1923.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 9 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Terminal Anuria

(Signed) C. A. Bracken, M. D.

, 19 (Address) 1218 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 22 1923
20 UNDERTAKER E. Schumacher Son	ADDRESS 1934 Pinkney St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 66

D 80105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 256 N. Bruce (St.) 19 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bannaker

(a) RESIDENCE NO. 256 N Bruce (St.) (Ward) Washington DC

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. 7 mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Bannaker

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE 43 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work railroad porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria, Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Sadie Bannaker

(Address) 256 N. Bruce

15 Filed OCT 21 1923

16 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-25-, 23, to 10-19-, 1923

that I last saw h alive on " ", 19

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH was as follows:

~~Acute~~ Chronic Cardiac Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. M. Cardozo, M. D.

, 19 (Address) 524 N. Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D C

DATE OF BURIAL Oct 21 1923

20 UNDERTAKER Saml J Hensley

ADDRESS W Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Alcoholism

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80106

CERTIFICATE OF DEATH.

129 D 80106

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Worsley ST. 17 WARD)

2-FULL NAME Mary Burley

(a) RESIDENCE NO. 406 Worsley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Burley (Address) 406 Worsley St.

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1923, to Oct. 19, 1923, that I last saw her alive on Oct. 19, 1923, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Hugh Forsyth M. D.

, 19 (Address) 424 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Lawn. DATE OF BURIAL Oct 21 1923

20 UNDERTAKER Samuel Wamsley ADDRESS 178 Eddy St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80107

CERTIFICATE OF DEATH.

X44 D 80107

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 25 WARD)

2-FULL NAME Willard Ott

(a) RESIDENCE NO. Emmettsburg, ST., WARD Emmettsburg Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Frances Ott

6 DATE OF BIRTH (month, day, and year) Apr 17 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68 —	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer St Josephs College

9 BIRTHPLACE (city or town) West Virginia
(State or country)

PARENTS

10 NAME OF FATHER George Ott

11 BIRTHPLACE OF FATHER (city or town) Ohio
(State or country)

12 MAIDEN NAME OF MOTHER Emma Caldwell

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Bernard Ott
(Address) Emmettsburg Md.

15 Filed OCT 21 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 - 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Right Pleural Effusion 8
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Shock. (duration) yrs. mos. 1 ds.

(Signed) G. C. Rader, M. D.
(Coroner)
(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmettsburg Md — DATE OF BURIAL Oct 21 1923

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 80108

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 80108

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1530 Mc Culloh St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann E. Hitchens.

(Residence in Baltimore: No. 1530 Mc Culloh St.; 76 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, March (Month) 17th (Day), 1847 (Year)

7-AGE, 76 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Samuel Hitchens

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Simms

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne E. Hitchens

(Address) 1530 Mc Culloh St.

15-

Filed....., 191.....

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 18 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4 1923, to Oct. 15 1923, that I saw h— alive on Oct. 15 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pyemia - Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tb (Duration) ....yrs. ....mos. 3 ds.

(Signed) ..... M. D.

Oct. 18, 1923 (Address) 1530 Mc Culloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct. 22nd, 1923

20-UNDERTAKER Mrs Chas. H. Riley

ADDRESS 1121 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80109

CERTIFICATE OF DEATH.

129 D 80109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1109 Ashland Av St., 10 WARD)

2-FULL NAME John Kane

(a) RESIDENCE No. 1109 Ashland Av ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colard

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE 50 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): D.C

PARENTS

10 NAME OF FATHER: Jonas Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country): D C

12 MAIDEN NAME OF MOTHER: Amanda Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D C

14 Informant: Jonas Kane
(Address) 1109 ashland ave

15 Filed OCT 21 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to October 19, 1923, that I last saw him alive on October 19, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Asthma Chronic Bright Disease

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Asthma Chronic Bright Disease (duration) yrs. 4 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr L W Kennard M. D.

10-19, 1923 (Address) 708 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green cemetery

DATE OF BURIAL: Oct 21 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

D 80110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Aisquith ST., 3 WARD)

2-FULL NAME Joseph W Newman

(a) RESIDENCE NO. 115 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 [illegible] 3

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	4	9	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant [illegible]

(Address) [illegible]

15 Filed OCT 21 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 , 19 23 , to Oct 20 , 19 23 ,

that I last saw h[illegible] alive on Oct 20 , 19 23 ,

and that death occurred, on the date stated above, at 330 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chron. Thyrocardiac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Bayliss, M. D.

10/20, 19 23 (Address) 210 Aisquith.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 10/21 19 23

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Cor.—1-12-23—M&T—100 Bks.

D 80111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 80111

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1353 N. Gilmor St., 15 WARD)

2-FULL NAME Christine Riefle

(a) RESIDENCE No. 2322 Reisterstown Rd ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Riefle

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jacobina Rohrbeck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Geo. F. Riefle
(Address) 2500 Reisterstown Rd.

15 Filed OCT 21 1923 ROBERT R. KRAUT...
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)

Oct. 20, 1923 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Oct. 22 1923
20 UNDERTAKER John O. Mitchell	ADDRESS 2120 W. Fayette St.

Before signing, see that all items are correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80112

CERTIFICATE OF DEATH.

94-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2300 Garrison Ave St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Agusta Bushey

(a) RESIDENCE NO. 2300 Garrison Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or ~~divorced~~ (of) HUSBAND of (or) WIFE of: J. H. Bushey

6 DATE OF BIRTH (month, day, and year): March 2, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town) New London, (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Hohea J Brownell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Md

12 MAIDEN NAME OF MOTHER Louisa Hammond

13 BIRTHPLACE OF MOTHER (city or town) New London (State or country) Frederick Co Md

14 Informant: Richard F Brownell

(Address) 2300 Garrison Ave

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Oct 19 1923.

that I last saw h[illegible] alive on Oct 19 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

48 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Chronic

Nephritis - Chronic [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry L. Algire, M. D.

Oct 19 23 (Address) 3640 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Mt Olivet — DATE OF BURIAL: OCT 22 1923

20 UNDERTAKER: Geo W Little — ADDRESS: 2208 Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80113

CERTIFICATE OF DEATH.

90 D 80113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1716 Appleton ST., 15 WARD)

2-FULL NAME Virginia A Skelton

(a) RESIDENCE NO. 1716 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rodney W. Skelton

6 DATE OF BIRTH (month, day, and year) Feb 19 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Reg. W. Skelton

(Address) 1401 E. North Ave.

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1923

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19 23 to Oct 19, 19 23, that I last saw h alive on Oct 19, 19 23, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of Heart

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L Sanderson M. D.

, 19 (Address) 1710 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 22 1923

20 UNDERTAKER Wm J. Pickett & Sons. ADDRESS Notarta

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80114

84 ✓ D 80114

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 N. Fulton Ave ST., 15 WARD)

2-FULL NAME James Joseph Nagle

(a) RESIDENCE NO. 1632 N. Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Nagle

6 DATE OF BIRTH (month, day, and year): Mar 5 1870

7 AGE — Years: 53 — Months: 7 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: Michael Nagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Catherine Nagle

(Address): 1632 N. Fulton Ave.

15 Filed ..... 19 .....

OCT 21 1923 ROBERT R. KRAUTER, BUREAU OF VITAL STATISTICS

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 ..... 19 ..... to Oct 19th 19 23.

that I last saw h[illegible] alive on Oct 19 ..... 19 23,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebellar New Growth + Tumor of Brain

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Coma Ordema Lungs

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Gilcreas, M. D.

19 (Address) 15 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 23, 1923

20 UNDERTAKER: Wm. J. Rickerssons — ADDRESS: Norwalk

Spec.—1-10-21—M&T—1500 Bks.

D 80115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80115

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 S. Kenwood Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Baumbach

(a) RESIDENCE NO. 932 S. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 30 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Prill
(Address) 932 S. Kenwood Ave

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 19 , 1923 , to — , 19 — ,

that I last saw h[illegible] alive on Oct 19 , 1923 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchs - Pneumonia

Cardiac Decompensation

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A T Ries , M. D.

Oct. 20 1923 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Oct, 22 1923

DATE OF BURIAL

20 UNDERTAKER John F. Weber

ADDRESS 1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

D 80116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 80116

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3951 Roland Ave ST., 13 WARD)

2-FULL NAME Caroline A. Shay

(a) RESIDENCE NO. 3951 Roland Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Shay

6 DATE OF BIRTH (month, day, and year): Oct. 16 1870

7 AGE — Years: 53 — Months: — — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: John H. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): John A. Shay 3951 Roland Ave

15 Filed OCT 21 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Oct 19 1923 that I last saw her alive on Oct. 19 1923 and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 8 mos 18 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) C. T. Kinsolving M. D.

Oct 19 24 (Address) 2201 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hamden) — DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: Horace F. Burger — ADDRESS: 363 Hall Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80117

CERTIFICATE OF DEATH.

49

D 80117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 812 Bare St. 21 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Oneil.

(a) RESIDENCE No. 812 Bare St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E. Oneil

6 DATE OF BIRTH (month, day, and year): Aug 10 1858

7 AGE — Years: 65 — Months: 2 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Michael Oneil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Frances Groves

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Margaret E. Oneil

(Address): 812 Bare St

15 Filed OCT 21 1923, ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15 1923 to Oct 21 1923, that I last saw him alive on Oct 20 1923, and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 2023

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herman B Freeman M. D.

19 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 23, 1923

20 UNDERTAKER: George J. Smith — ADDRESS: 1537 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001 D 80118

D 80118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Jordan

(a) RESIDENCE NO 618 N. Eden St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) March 29/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Douglas Jordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maud Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Douglas Jordan
(Address) 618 N. Eden

15 Filed OCT 21 1923 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myeloid Leukemia

(Autopsy at hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Hatten, M. D.
(Coroner.)

10/20/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 21 1923
20 UNDERTAKER Mrs. R. C. Elliott	ADDRESS 722 Linden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-21—M&T—100 Blks.

Anthony F Benke.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80119

CERTIFICATE OF DEATH.

188-003 D 80119

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony F. Benke

(a) RESIDENCE NO 921 S.Curley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) June 7/1916

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	7	4	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School-boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.Md.
(State or country)

PARENTS

10 NAME OF FATHER Paul Benke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Thersa POLCHINSKA

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Paul Benke
(Address) 921 S. curley St.

15 Filed OCT 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-rt. side and at base (Accidental- struck by autotruck, inquest to be held Oct. 22/23)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J S Mallen, M. D.
(Coroner.)

10/20/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loud Heart Cem.	10/22 23
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S Wolfe St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80120 ✓ 44 D 80120.

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 80 Third Ave, E. Brooklyn ST.: 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Brenner

(a) RESIDENCE. No. 80 Third Ave, E. Brooklyn ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wh	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adart Brenner

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	,,	,,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Mrs. Schultz Daughter. 80 Third Ave E. Brooklyn

15 Filed OCT 21 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1923, to Oct 18, 1923, that I last saw her alive on Oct 18, 1923, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma, probably, liver and gall bladder

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Only Physical signs as age prohibited biopsy test.

(Signed) Robt W Johnson M. D.

19 (Address) Brooklyn Bell Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Crem., A.A. Co.	Oct. 22nd 1923

20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80121

CERTIFICATE OF DEATH.

D 80121

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1709 N. Bentalou (St.) 15 (Ward)

2-FULL NAME Emma E. Burkhardt

(a) RESIDENCE. No. 1709 N. Bentalou St., ... Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of George Burkhardt

6 DATE OF BIRTH (month, day, and year) Dec-11-1864

7 AGE — Years: 59 — Months: 9 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. Schanze

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry Gelt
(Address) 1709 N. Bentalou St

15 Filed OCT 21 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14th, 1923, to Oct 18th, 1923, that I last saw her alive on Oct 18th, 1923, and that death occurred, on the date stated above, at 9 40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) one yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? yes Date of May 15th 1923

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Microscopical

(Signed) Wm. H. Hunter, M. D.

10/19 1923 (Address) 1701 N. Bentalou

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: 10/22 23

20 UNDERTAKER: M. Daly & Son

ADDRESS: 1822 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operated upon for removal of left breast at St Agnes Hospital May 5th 1923 by Dr. Jos. C. Bloodgood.

(Carcinoma of breast)

WA

Spec.—1-10-21—M&T—1500 Blks.

D 80122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 80122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Dillon ST. 1 WARD)

2-FULL NAME Stanislawa Kordonska

(a) RESIDENCE No. 2700 Dillon ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HouseWife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Marcin Burzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kosmicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Kordonski

(Address) 2700 Dillon St.

15 Filed OCT 22 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1923, to October 19, 1923, that I last saw h[illegible] alive on Oct. 14, 19[illegible] and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

cystic tumor of ovary

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Jannuzzi, M. D.

10/24 19[illegible] (Address) 2431 Fait

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem DATE OF BURIAL Oct 23 1923

20 UNDERTAKER Stephen J. Fialkowski ADDRESS 1000 Kenyon Ave

Cor.—1-12-23—M&T—100 Bks.

D 80123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 80123

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 W. Hill St. ST., 22 WARD)

2-FULL NAME Edward J. Bolden. C.

(a) RESIDENCE NO 213 W. Hill st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Widower.

5a If married, widowed, or divorced (HUSBAND) of (WIFE) xxxxxxx Maggie Bolden. C.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER John Bolden. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge, Md.

12 MAIDEN NAME OF MOTHER Matilda. ----(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge, Md.

14 Informant Barry Bolden. (C) son.
(Address) 515 N. Carlton st.

15 Filed ..... 192 ..... Registrar

ROBERT F. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Oct, 20, 1923 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Oct 22 192[illegible]

20 UNDERTAKER L. V. Brown & Son

ADDRESS 108 N. Mary

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Anna Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

14-002

D 80124

CERTIFICATE OF DEATH

14 D 80124

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME Anna Williams

(a) RESIDENCE NO. 117 W. Hughes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) ~~Wife~~ of: Martha Williams

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 42; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Do

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto. Md.

15 Filed OCT 22 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923 to Oct 19, 1923

that I last saw him alive on Oct 19, 1923

and that death occurred, on the date stated above, at 12-20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

CONTRIBUTORY (Secondary) (duration) Cerebral Hemorrhage yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldsmith M. D.

10/19/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion

DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: A. L. Blount & Son

ADDRESS: 108 N. Monty

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No History

Spec.—1-10-21—M&T—1500 Bks.

D 80125

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D 80125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleonora Maddox

(a) RESIDENCE NO. 901 Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eley Gilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Ida Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed OCT 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 17, 19 23, to October 19, 19 23,

that I last saw her alive on October 18, 19 23,

and that death occurred, on the date stated above, at 4:10 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis.

Syphilitic Aortitis.

Aortic Insufficiency

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Ist Autopsy

(Signed) Chas. E. Ivan, M. D.

19 10-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL Oct 23 19 23

20 UNDERTAKER J. L. Brandt & Son — ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80126

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 80126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 E. Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hilditch

(a) RESIDENCE No. 1528 E. Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. E. Hilditch

6 DATE OF BIRTH (month, day, and year) Jan 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer) 007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Hilditch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Mc Cotter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Wm. H. Hilditch

(Address) 1528 E. Biddle St.

15 Filed , 19 Registrar

OCT 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Oct 20, 1923

that I last saw h[illegible] alive on Oct 20, 1923

and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon Abrahams, M. D.

Oct 21 1923 (Address) Cecil Bldg Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 10/23 1923

20 UNDERTAKER J. Fenn McCarthy — ADDRESS 430 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D 80127

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Frank C Williamson Jr

(a) RESIDENCE No. 1348 N Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 6 mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~: (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 19 March, 1921

7 AGE: Years 2 | Months 7 | Days ..... | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Frank C Williamson Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md

12 MAIDEN NAME OF MOTHER Ida Tudor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank C Williamson Jr

(Address) 1348 N Washington St

15 Filed OCT 22 1923, 19..... ROBERT R KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 October 19 1923

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1923 to October 19, 1923, that I last saw him alive on October 19, 1923 and that death occurred, on the date stated above, at 6:20 P m.

The CAUSE OF DEATH* was as follows:

Poisoning with lead, 3 weeks. +

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Encephalitis (lead) 11 ds. +

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) H. H. Mech, M. D.

10/19, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: 10/23 1923

20 UNDERTAKER: Albert L. Hiltz Jr — ADDRESS: 1606 N Chester St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chauffeur [illegible] of
Furniture - Packers

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80128 D 80128

101-004

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1034 Pleasington (St.) 18 (Ward)

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Bevens

(a) RESIDENCE No. 1034 Pleasington St., Ward _____ (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 27, 1920

7 AGE — Years: 2 — Months: 11 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston (State or country) Md

PARENTS

10 NAME OF FATHER George H. Bevens

11 BIRTHPLACE OF FATHER (city or town) Accomack (State or country) Va

12 MAIDEN NAME OF MOTHER Henerva Gaskins

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co. (State or country) Va

14 Informant George H. Bevens (Address) 1034 Pleasington St

15 Filed OCT 22 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1923. to Oct 19, 1923. that I last saw her alive on Oct-19, 1923, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) _____ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. F. Howell M. D.

(Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Oct. 22, 1923

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

(State or country) Md

14 Informant (Address) Geo H. Bevan, 100 Lexington St

15 Filed OCT 22 1923 19 Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

20 UNDERTAKER Mrs Katie R. Williams

DATE OF BU... Oct

ROBERT R. KRAUTER, Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 80129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Holbrook St., 9 WARD)

2-FULL NAME Antonia Ernest

(a) RESIDENCE NO. 1644 Holbrook St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Ernest

6 DATE OF BIRTH (month, day, and year): Jan 10 1891

7 AGE: Years 32 Months 9 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Roetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Lilla Gookopsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Edward Ernest, 1644 Holbrook St.

15 Filed ... 19 ... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12. 1923. to Oct. 20. 1923.

that I last saw h[illegible] alive on Oct. 20. 1923.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Weakness of the Heart

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible] J. Sobel, M. D.

, 19 (Address) 1001 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: Frank A. Fink ADDRESS: 915 N. Gay St.

Cor.—1-12-23—M&T—100 Blks.

D 80130 HEALTH DEPARTMENT—CITY OF BALTIMORE 80130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. X 188-03

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roman Ayers

(a) RESIDENCE NO. Jarrettsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer, Odd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Don't know

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richard Ayers
(Address) Jarrettsville Md.

15 Filed OCT 22 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental in Cause

(duration) yrs. mos. ds.

(Signed) W H Gorsuch (Coroner.), M. D.

Oct 22 192 3 (Address) Jarrettsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jarrettsville Md	Oct 23 1923
20 UNDERTAKER	ADDRESS
Ed B Hoke	115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80131

CERTIFICATE OF DEATH.

100-001

D 80131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1443 Light (St.) 24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mullen

(a) RESIDENCE NO. 1443 Light St. (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna F. Mullen

6 DATE OF BIRTH (month, day, and year): Jan 29, 1849

7 AGE: Years 74 | Months 8 | Days 20 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 06

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margt Parnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mrs Anna Mullen

(Address): 1443 Light St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1923, to Oct 19, 1923,

that I last saw h... alive on Oct 19, 1923,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebro-hemorrhage.

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) / Senility

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of,

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) ..... M. D.

....., 19 (Address) 2 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Oct 22 1923

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 80132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 80132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 St. Paul St. WARD)

2-FULL NAME Joseph J. Brown

(a) RESIDENCE NO. 614 N. Paca St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Brown

6 DATE OF BIRTH (month, day, and year) Aug 27 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	50	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Theodore Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Patient. (Md Gen'l Hosp)

15 Filed OCT 22 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-23 19

17 I HEREBY CERTIFY, That I attended deceased from 9-25-23, 19 to 10-20-23, 19

that I last saw h alive on 10-20-23, 19

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis, Ch. Endocarditis (Aortic Stenosis)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Albumin & Casts

(Signed) Thos A. Scampini, M. D.

19 (Address) City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R. C.	Oct 23 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80133

CERTIFICATE OF DEATH.

90 D 80133

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 919 Jordan ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Cornish

(a) RESIDENCE NO. 919 Jordan ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE: 66 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Cambridge (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hattie Fellow (Address) 319 N Pine

15 Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Oct 20, 1923, that I last saw her alive on Oct 19, 1923, and that death occurred, on the date stated above, at 1205 a m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William E Burton, M. D.

Oct 20 1923 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 10-22 1923

20 UNDERTAKER: David Easton — ADDRESS: 916 Penna ave

Spec.—1-10-21—M&T—1500 Bks.

80134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 80134

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Rutter St. 14 WARD)

2-FULL NAME Leonia Washington

(a) RESIDENCE NO. 1414 Rutter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 9-1923

7 AGE: Years — Months 4. Days — If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Leono Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Washington (Address) 1414 Rutter St

15 Filed ..... 19 ..... Registrar

OCT 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-192

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th 1923 to Oct 21 1923

that I last saw her alive on Oct 20th 1923

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Catarrh

or Cholera Infantum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Grantham M. D.

19 (Address) 854 N. Caddie St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-23 1923

20 UNDERTAKER David Easton

ADDRESS 916 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. —6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 80135

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 N Bruce ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Brown

(a) RESIDENCE. No. 323 N Bruce ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Roasting Coffee Spice Mill Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Peter Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Tom Brown

(Address) 323 N. Bruce St

15 Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1923

17 I HEREBY CERTIFY, That I attended deceased from Sep 14, 1923, to Oct 20, 1923, that I last saw h[illegible] alive on Oct 18, 1923, and that death occurred, on the date stated above, at 5:25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) John C Stewart, M. D.

, 19 (Address) 704 W Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Funding Co DATE OF BURIAL 10-23-1923

20 UNDERTAKER David Fowler ADDRESS 916 Penna Ave

Spec.—1-10-21—M&T—1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80136

CERTIFICATE OF DEATH.

D 80136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Cecil Apts ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McCullough

(a) RESIDENCE NO. Cecil Apts ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 95 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? 95 yrs. 10 mos. 23 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George McCullough

6 DATE OF BIRTH (month, day, and year): Nov-27-1827

7 AGE — Years: 95 Months: 10 Days: 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: William Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Anna Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Miss Nellie St. Proctor (niece)

(Address): Cilman Apts

15a Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20- 1923.

17

I HEREBY CERTIFY, That I attended deceased from [illegible], 1922, to Oct. 19- 1923.

that I last saw her alive on Oct. 14th 1923.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage occurring Dec. 1922.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No. What test confirmed diagnosis? Apparent [illegible]

(Signed) [illegible], M. D.

, 19 (Address) 1705 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY

(WILLIAM F. MOWEN, Supt.)

ADDRESS: 103 W. NORTH AVE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

145-001

D 80137

CERTIFICATE OF DEATH.

D 80137

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: NO. Lombard & Greene STS. University (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Smith

(a) RESIDENCE NO. 804 Wandyes ST. Baltimore BOARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 16 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Knot Moody.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Esther Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: University Hospital Records
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 21, 1923, that I last saw h[illegible] alive on Oct 21, 1923, and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:

Puerperal infection
Septicemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cesarean Section. Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? Yes Date of Oct 10-1923

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W Wallace Walker M. D.

. 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 10-24-23

20 UNDERTAKER: David Easton — ADDRESS: 916 E. [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

Southern Wilkins

D 80138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80138

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 1311 Riggs ave ST. 16 WARD)

2-FULL NAME Southey Wilkins

(a) RESIDENCE. No. 1311 Riggs ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta Wilkins

6 DATE OF BIRTH (month, day, and year) Oct 12, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Steamers

(c) Name of employer Chesapeake Company

9 BIRTHPLACE (city or town) (State or country) Northampton Co Va.

PARENTS

10 NAME OF FATHER Esquire Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northampton Co. Va.

12 MAIDEN NAME OF MOTHER Mary Hunting[illegible] Oct 19 19 23

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Co. Va.

14 Informant Alberta Wilkins
(Address) 1311 Riggs ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1923, to Oct 19, 1923, that I last saw h— alive on Oct 18, 1923, and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastric

Pylorus (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical -

(Signed) William H Wright, M. D.

(Address) 1209 Preston and

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-22-23
20 UNDERTAKER	ADDRESS 916
David Fortier	Dennison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 22 1923

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 80139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80139

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1811 N. Durham St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance V. Miller

(a) Residence No. 1811 N. Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mina Miller

6-DATE OF BIRTH (month, day and year): Dec. 23 1865

7-AGE: 57 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): U.R.R. Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: John Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant): Mina Miller

(Address): 1811 N. Durham St.

15-

Filed OCT 22 1923 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): October 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from One year ago, 19.. to Oct 19 1923

that I last saw h.. alive on Oct 19 23 19..,

and that death occurred, on the date stated above, at 1 30 A.m.

The CAUSE OF DEATH* was as follows:

Cancer Intestines

Duration per Laber & Gray

(Duration).....yrs.....mos.....ds

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Evidence

(Signed) Wesley M. D

, 19 (Address) 1639 Druid

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	Oct 22 1923
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80140

D 80140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4814 Augusta Ave. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Vincent Rock.

(a) RESIDENCE NO. 4814 Augusta Ave. ST., ..WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E Rock.

6 DATE OF BIRTH (month, day, and year) May 25. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Setter

(b) General nature of industry, business, or establishment in which employed (or employer) 615

(c) Name of employer Miller Harrison Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Rock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Geo. Rock (Address) 4814 Augusta ave.

15 Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18. 1923. to Oct. 20. 1923.

that I last saw him alive on Oct. 21 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus.

/ (duration) / yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Jos. J. Schaller, M. D.

, 19 (Address) 4707 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery. DATE OF BURIAL Oct 23 1923

20 UNDERTAKER McGinnis & Conrad ADDRESS 4203 Ridgewood Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D 80141

CERTIFICATE OF DEATH.

D 80141

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 8 WARD)

2-FULL NAME Alice Holton

(a) RESIDENCE NO. 1812 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): January 6 - 1862

7 AGE: 61 Years: 61 Months: 0 Days: 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 064

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John F. Holton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Cobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mamie Fox

(Address): 1812 E. Biddle St

15 Filed OCT 22 1923 19 Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1923, to Oct 20, 1923, that I last saw h alive on Oct. 20, 1923 and that death occurred, on the date stated above, at 1:20 A.m.

The CAUSE OF DEATH* was as follows:

Generalized abdominal carcinomatosis

(duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 10. 11. 23.

Was there an autopsy? no

What test confirmed diagnosis? Exploratory laparotomy

(Signed) Vincent Kmoda, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Ground

DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: Fred Schnorr

ADDRESS: 1411 E. Biddle St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of Sigmoid Flexure

Spsc.—6-9-19—H. P. Co.—1000 Bks.

D 80142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80142

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 E. Cross. ST.: 24th WARD)

2-FULL NAME. Sallie Maria Barnes

(a) RESIDENCE. No. 134 E. Cross ST., 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: John Cornelius Barnes

6 DATE OF BIRTH (month, day, and year): Oct 16, 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St. Mary's Co. Maryland.

PARENTS

10 NAME OF FATHER: Wm. Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Mary's Co Maryland.

12 MAIDEN NAME OF MOTHER: Celesta Joy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Mary's Co. Maryland.

14 Informant: Mrs. Mary Lumpkin (daughter)

(Address) 134 E. Cross St.

15 Filed . 19 . Registrar

OCT 22 1923 ROBERT R. KRAMER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1923, to October 21, 1923

that I last saw her alive on October 20, 1923,

and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 15 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

. 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cherry Hill Cem. DATE OF BURIAL: 10/24 1923

20 UNDERTAKER: E. A. B. Hale & Co. ADDRESS: 115 E. [illegible] St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1 × 185

D 80143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chauncey Wetzel

(a) RESIDENCE NO. Woodlawn, Balto Co. ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lela Wetzel

6 DATE OF BIRTH (month, day, and year) Feb - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Ezekiah Wetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Amanda Strawsburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant University Hosp. Records (Address)

15 Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1923, to Oct 22 1923 that I last saw h. / M alive on Oct 22, 1923, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Abscess of the Lung (following trauma)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) David R. Newcomer, M. D.

Oct 22 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bromberg Church Cemetery DATE OF BURIAL Oct 24 1923

20 UNDERTAKER George J. Smith ADDRESS 1592 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall
from scaffold

Spec.—1-10-21—M&T—1500 Bks.

16163 80144

HEALTH DEPARTMENT—CITY OF BALTIMORE

13 D 80144

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS H[illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 18 WARD)

2-FULL NAME Robert Hilldebrand

(a) RESIDENCE NO. 837 N. Wolfe ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred White mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 - 1923

7 AGE — Years: - Months: 3 Days: 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Hilldebrand

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Elsie Otts

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Mrs A Hilldebrand (Address) 1017 N. Aisquith St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 19 - 1923, to Oct 21, 1923,

that I last saw him alive on Oct 21, 1923

and that death occurred, on the date stated above, at 845 a. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

Marasmus

~~Otitis~~

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas. R Bagg, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL: Oct 22 19

20 UNDERTAKER: R S Fitzpatrick ADDRESS: 223 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Geldmacher

HEALTH DEPARTMENT—CITY OF BALTIMORE

80145 — CERTIFICATE OF DEATH. — 80145

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH Bayview Hospital 70 — REGISTERED NO. 100

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Geldmacher

(a) RESIDENCE NO. 611 S. Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 66 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Geldmacher

6 DATE OF BIRTH (month, day, and year): Sept 15 1857

7 AGE: Years 66 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. H. Lincoln

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lucy M. Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Bayview Hosp

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to Oct 21, 1923

that I last saw h alive on Oct 21, 1923

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N Goldsmith M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: F. B. Stephens — ADDRESS: 2236 Frederick Ave

OCT 22 1923 Burial Permit

Spec.—1-10-21—M&T—1500 Bks.

D. H. Jones

D 80146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80146

CERTIFICATE OF DEATH.

13

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 (St.) Brunswick (Ward) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Gertrude Ley (Rey)

(a) RESIDENCE No. 525 Brunswick St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 18/23

7 AGE — Years: — Months: 2 Days: 3 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Geo. L. Ley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Susan Pollock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Geo. L. Ley

(Address): 525 Brunswick St.

15 Filed OCT 22 1923 19 ROBERT R. KRAUSER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Oct 21, 1923,

that I last saw h[illegible] alive on Oct 21, 1923,

and that death occurred, on the date stated above, at ~~Oct 21~~ 5 P m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteric Intoxication

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H W Jones M. D.

19 (Address) 22 E Lex. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: J B Heppert

ADDRESS: 226 Fred'k Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80147

CERTIFICATE OF DEATH.

1/2 D 80147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 S. Bond ST., 12 WARD)

2-FULL NAME Weronika . Wielopski

(a) RESIDENCE NO. 831 S. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24 1918

7 AGE: Years | Months 5 | Days 3 | LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph. Wielopski

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Weronika Mosna

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr Joseph. Wielopski
(Address) 831 S. Bond Street

15 Filed OCT 22 1923, 19 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Oct. 21, 1923,

that I last saw her alive on Oct 20, 1923,

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Alice Anna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Csc

DATE OF BURIAL: 22 1923

20 UNDERTAKER: Lohmeweber

ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Clarence Collins

D 80148

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 ✓ D 80148

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U S Marine Hosp. St., 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Collins Clarence

(a) RESIDENCE NO. 936 Argyle Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter (Merchant Marine)

(b) General nature of industry, business, or establishment in which employed (or employer) (Merchant Marine

(c) Name of employer ? 070

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ? 1/21. 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant U. S. Marine Hosp

(Address)

15 Filed OCT 22 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 1923

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1923, to Oct 21, 1923

that I last saw h in alive on Oct 21, 1923

and that death occurred, on the date stated above, at 5.20 9 m.

The CAUSE OF DEATH* was as follows

Tuberculosis Pulmonary Chronic

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive Sputum

(Signed) M. N. Foster M. N. Foster M. D.

(Address) U. S. Marine Hospital C.J.M.S. No.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL 10/22 1923

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80149 D 80149

CERTIFICATE OF DEATH.

90 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Phila Ave ST., WARD)

2-FULL NAME Rosalia Rochlitz

(a) RESIDENCE No. 2804 Philadelphia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher J. Rochlitz

6 DATE OF BIRTH (month, day, and year) Aug 5 1/37

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Jos. Massek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Josephine Rochlitz

(Address) 2804 Phila ave

15 Filed OCT 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Oct 20, 1923, that I last saw her alive on Oct 20, 1923, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of the Heart

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hyam Fried M. D.

, 1923 (Address) 913 N. Charles str.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 24 1923

20 UNDERTAKER Philip Hennig — ADDRESS 206 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80150

CERTIFICATE OF DEATH.

24

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2615 Keyser ST., 8 WARD)

2-FULL NAME Evelyn Webster

(a) RESIDENCE NO. 2615 Keyser ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Singl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 27 21

7 AGE — Years: 2 — Months: 5 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): White

PARENTS

10 NAME OF FATHER: Artie Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Reita L. Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Artie Webster
(Address): 2615 Keyser

15 Filed ....., 19 .....

OCT 22 1923

ROBERT P. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-21 19 3

17

I HEREBY CERTIFY, That I attended deceased from 10-21, 19 23 to 10-22, 19 3,

that I last saw h[illegible] alive on 10-21 19 3

and that death occurred, on the date stated above, at 8 7 m.

The CAUSE OF DEATH* was as follows:

Acute Cerebro Spinal Meningitis

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. L. Rauch, M. D.

10/22 19 (Address) 2939 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bulls Gem — DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ofc Denne

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80151

CERTIFICATE OF DEATH.

45 D 80151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2530 Guilford Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frank Dew

(a) RESIDENCE NO. 2530 Guilford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	~~5 Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Conn Dew

6 DATE OF BIRTH (month, day, and year) April 19th, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna Railroad Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Dew

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah McMains

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Agnes C. Dew

(Address) 2530 Guilford Ave

15 Filed OCT 22 1923, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Oct 21, 1923, that I last saw him alive on Oct 21, 1923, and that death occurred, on the date stated above, at 4:40 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Cecum

(duration) about yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? X Ray

(Signed) Jos Herbert M. D.

, 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 23rd 23

20 UNDERTAKER Watson & Co

ADDRESS 423 N Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80152

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 80152

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 S. Bouldin St., 96 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip W. Boehm

(a) Residence No. 916 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 24-1923

7-AGE. yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Ans

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Edward Boehm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Catharine Weinholt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Catharine Boehm

(Address) 916 S. Bouldin St.

15- Filed, OCT 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk, 109. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 21-1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1923, to Oct. 21, 1923

that I last saw h.im alive on Oct 21, 1923

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Derbyshire Co M. D

10/21, 1923 (Address) 806 S. 3rd St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Oct 23, 1923
20-UNDERTAKER	ADDRESS
Zickler & Zickler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

January 8

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80153 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80153

CERTIFICATE OF DEATH.

16-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 S. Bouldin St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Klingenhafer

(a) Residence No. 1012 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 26-1922

7-AGE. — yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Frederick Klingenhafer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Jennie Kacymarek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

11- (Informant) Frank Klingenhafer

(Address) 1012 S. Bouldin St.

13- Filed OCT 22 1923, 192... Registrar. Hall

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22-1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1923 to Oct 22 1923

that I last saw h[er] alive on Oct 21 1923

and that death occurred, on the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery Acute

(Duration)..... yrs. ..... mos. 10 ds.

CONTRIBITORY (Secondary) Bronchopneumonia

(Duration)..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tipton M. D

10/22, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Buried Holt — DATE OF BURIAL, Oct. 24 1923

20-UNDERTAKER, Forrest Funeral Home — ADDRESS 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *scpticemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Bacillary

Wilson 33 S. Fulton

Spec.—1-10-21—M&T—1500 Bks.

D 80154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80154

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Ashton ST. 70 WARD)

2-FULL NAME Mary Hittel

(a) RESIDENCE NO. 2104 Ashton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Martin C. Hittel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Hittel

(Address) 2104 Ashton

15 Filed OCT 22 1923 19 ..... H. Lee Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10. 1923 to Oct 20. 1923, that I last saw her alive on Oct 20 1923 and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis,

(duration) 2 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Jos R. Wilson, M. D.

, 19 (Address) 33 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 10/24 1923

20 UNDERTAKER William Cook — ADDRESS 502 E Nav

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80155

CERTIFICATE OF DEATH.

90 D 80155

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Tarleton

(a) Residence No. Preston & Caroline Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, Widowed, ~~or Divorced~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Tarleton

6-DATE OF BIRTH (month, day and year) Aug-1847.

7-AGE. 76 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Scotland.

PARENTS

10-NAME OF FATHER. John Dougherty.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Antrim

12-MAIDEN NAME OF MOTHER. Hannah Quigley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Antrim

11- (Informant) Sister Superior

(Address) Preston & Caroline Sts.

15- Filed OCT 22 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/21/23

17- I HEREBY CERTIFY, That I attended deceased from 10/20 1923 to 10/21 1923

that I last saw h. Sr alive on 10/20 1923

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Bernard Lords M. D.

10/22 1923 (Address) 914 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Annapolis

DATE OF BURIAL. Oct 22 1923

20-UNDERTAKER. Jas S. Taylor & Sons

ADDRESS Annapolis

Spec.—1-10-21—M&T—1500 Bks.

D 80156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 80156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST. 9 WARD)

2-FULL NAME Miss Clara Morris

(a) RESIDENCE NO. 1008 E. North Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: ditto

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Saml Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Miss Anna Morris

(Address) 1008 E North Ave

15 Filed ..... 19 .....

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1923 to Oct 19th 1923.

that I last saw her alive on Oct 19th 1923

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Collapse following operation for fecal fistula

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction & peritonitis (local)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10-18-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Monninger, M. D.

10th, 1923 (Address) St Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: H. C. Brudfield

ADDRESS: Frumtown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Catharine May Holt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80157

CERTIFICATE OF DEATH.

X 19 D 80157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Holt, May

(a) RESIDENCE NO. 110 Moffett St. Elkton, Md. ST., ... WARD ELKTON, MD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 2 1862.

7 AGE: Years 61 Months 5 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer): W

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Washington Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Elizabeth Holt
(Address) Elkton Md.

15 Filed OCT 22 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1923, to Oct 22, 1923, that I last saw her alive on Oct 22, 1923, and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the head of the pancreas
(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Complete obstruction common bile duct
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 15, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry C P Wilson Jr., M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: North East Md — DATE OF BURIAL: Oct 22 1923

20 UNDERTAKER: Wm Fickner Sons — ADDRESS: North East Md

Cor.—1-12-23—M&T—100 Bks.

D 80158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80158

CERTIFICATE OF DEATH.

X 128

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Mable Thomas Brel

(a) RESIDENCE NO. 643 Rebory ST., WARD New Windsor Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colr	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 1

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Budd Sr

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Matilda

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address)

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL
Mt Olivet. Md. Oct 24 1923

20 UNDERTAKER H Bankard & Son ADDRESS Westminster Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 22 1923

ROBERT E. LAZARUS, Registrar of Vital Statistics

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 80159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80159

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Upshaw

(a) Residence No. 1904 Edding st. (910 McCulloh st) St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widow Widowed, or Divorced, (Write the word.)
Female	Colored	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS

10-NAME OF FATHER, Benjamin Bundy

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Kate McCoo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed ..... 192.. Registrar.

OCT 23 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1922 to Oct. 19 1923

that I last saw her alive on Oct. 19 1923

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secundary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum

(Signed) L. C. Lally M. D

10-20. 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Milford - Gasoline Cars DATE OF BURIAL 10 23 1923

20-UNDERTAKER James N. Lucas ADDRESS 1303 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80160

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2028 Druid Hill St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cornelius Ridgeway

(a) Residence No. 2028 Druid Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): Oct 11 1923

7-AGE. ..... yrs. ..... mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS:

10-NAME OF FATHER Charles Ridgeway

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Ada Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Ada Ridgeway

(Address) 2028 Druid Hill Ave

15- Robert F. Harrison, Burial Permit Clerk

Filed OCT 22 1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1923 to Oct 20 1923

that I last saw h— alive on Oct 20 1923

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows: Premature Birth, one

the same umbilicus. Period

of Uterine gestation

(Duration) yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 22, 1923 (Address) 1304 E. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon

DATE OF BURIAL, 10/23 1923

20-UNDERTAKER John H. Deems

ADDRESS 303 Cherry Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80161

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Robert ST., 14 WARD)

2-FULL NAME Elizabeth P. Harris

(a) RESIDENCE No. 405 Robert ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a ~~If married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Samuel Harris

6 DATE OF BIRTH (month, day, and year) Aug. 1847

7 AGE: Years 76 | Months 2 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset County (State or country) Md

PARENTS

10 NAME OF FATHER Gilbert Bolden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co. Md

14 Informant Katherine Harris (Address) 405 Robert St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19- ..., 1923, to Oct. 20 ..., 1923, that I last saw h-- alive on Oct. 20 ..., 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Chronic History

(Signed) James Brown, M. D.

10/24, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Co | DATE OF BURIAL: 8-D 23 1923

20 UNDERTAKER: Isaac D Hawsley | ADDRESS: W Fiddle

OCT 25 1923 Robert P. Garrison, Vital Records Clerk.

Cor.—1-12-23—M&T—100 Bks.

D 80162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80162

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 Druid Hill Ave. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Williford

(a) RESIDENCE NO 1937 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Odes Williford

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	40 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alfonso Devillis South America

PARENTS

10 NAME OF FATHER Alfonso Devillis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oklahoma

14 Informant (Address) Odes Williford 1937 Druid Hill Ave

15 Filed , 192 Registrar

DEC 22 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D. (Coroner.)

Dec. 24, 1923 (Address) 1807 N. Johnson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-24 1923
20 UNDERTAKER Saml H Handley	ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

D 80163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80163

CERTIFICATE OF DEATH.

REGISTERED No. C 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lacey Virginia Davis

(Residence in Baltimore: No. 1022 McCulloh St.; 0 yrs., 12 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH. Oct (Month) 3 (Day), 1922 (Year)

7-AGE. 1 yrs. 0 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James A. Garfield Davis

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Bessie Turner

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jay A. Davis

(Address) 1022 McCulloh St.

15-

Filed ....., 191....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CT221923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1923, to Oct 17 1923, that I saw her alive on Oct 17 1923, and that death occurred, on the date stated above, at 7:05 A m.

The CAUSE OF DEATH* was as follows:

Extreme Rickets and Malnutrition

Terminal Pneumonia

(Duration) 2 yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) 1 yrs. 2 mos. 0 ds.

(Signed) S. A. Dodds M. D.

Oct 22, 1923 (Address) 904 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. Oct 23 1923

20-UNDERTAKER Samuel Hensley ADDRESS 1128 Bdwy

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80164

D 80164

CERTIFICATE OF DEATH.

51

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Gilmor ST., 15 WARD)

2-FULL NAME Dorothy Mills

(a) RESIDENCE NO. 1416 Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 15-06

7 AGE: Years 17 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William E Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Glover

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Annie Mills 1416 Gilmor St

15 Filed ..... 19 ..... Registrar

OCT 22 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/20 1923

17

I HEREBY CERTIFY, That I attended deceased from 10/1 1923, to 10/20 1923, that I last saw h alive on 10/20 1923, and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Ac. Inf. Rheumatism

Ac. Pericarditis

(duration) yrs. mos 20 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Clutter, M. D.

10/22 1923 (Address) 2134 Dot

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: Samuel Handley

ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Eutaw pl ST., 17 WARD)

REGISTERED NO. 74-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Brooks

(a) RESIDENCE No. 1218 Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE: Years 84 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas Brooks (Address) 1218 Eutaw St

15 Filed OCT 22 1923 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 19 1923 to Oct 21 1923

that I last saw her alive on Oct 21 1923

and that death occurred, on the date stated above, at 6:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw J Whalley M. D.

Oct 22 1923 (Address) 1230 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Oct 23 1923

20 UNDERTAKER Samuel Stansbury ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80166

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 80166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 901 S Paca ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Lamp

(a) RESIDENCE NO. 901 S. Paca ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Paul R. Lamp

6 DATE OF BIRTH (month, day, and year) Aug 21 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Johann Ernst

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wyland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. B. Schmaltz
(Address) 1604 S Paca St

15 Filed OCT 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Oct 18, 1923

that I last saw h[illegible] alive on Oct 15, 1923

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. B. Thompson M. D.

Oct 19, 1923 (Address) 1604 Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL 10/23/23

20 UNDERTAKER Geo. J. Puth — ADDRESS 1235 Hanford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 14 Ward)

Registered No. 31

(If death occured in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Tennant

(a) Residence No. 1828 Madison ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Alex. W. Tennant

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Nannie W. Poisal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). West Virginia

14- (Informant) Hospital Records

(Address) M.I.H.

15- Filed OCT 22 1923 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 19 1919 to Oct. 22 1923

that I last saw him alive on Oct. 22 1923

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum - X-ray

(Signed) L. C. Lally M. D.

10-22 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cem

DATE OF BURIAL. Oct 24 1923

20-UNDERTAKER. John Whitelock

ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 22 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80168

CERTIFICATE OF DEATH.

D 80168

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1067 N. Calvert ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen M. Thomas

(a) RESIDENCE NO. 1067 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~ or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1847

7 AGE: Years 76; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 020

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Capt Charles I Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Maryland

12 MAIDEN NAME OF MOTHER: M. R. Poe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto County Md

14 Informant: Ellen F Ridgely

(Address): 1067 N Calvert St

15 Filed ....., 19.... Registrar

ROBERT R. KRAUTH

OCT 23 1923

CHIEF REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from September 15 1923, to October 21 1923, that I last saw h[er] alive on October 21 1923, and that death occurred, on the date stated above, at 8-25 Pm.

The CAUSE OF DEATH* was as follows:

Cancer of spine

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency, Oedema of lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) A. D. Atkinson, M. D.

1923 (Address) 1010 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: Henry W Jenkins & Son — ADDRESS: Orchard & Fremont Sts

Spec—12-23-21—E.B.R.S.—400 Bks.

Josephine Aquillo

161-001

D 80169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80169

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 W. Saratoga St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Josephine Aquilla

(a) Residence No. 125 W. Saratoga St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. 1 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem'l

4-COLOR OR RACE: W'hte

5-Single, Married, Widowed, or Divorced (Write the word.): Wid'd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wid'd

6-DATE OF BIRTH (month, day and year): Sept 9- 23

7-AGE: ..... yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Wf'nd ddd

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) Balt (State or Country) Md.

PARENTS.

10-NAME OF FATHER: Samuel Aquilla

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Rose Sanchelopa

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14- (Informant) Samuel Aquilla

(Address) 725 W. Saratoga St.

15- Filed OCT 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 22 23

17- I HEREBY CERTIFY, That I attended deceased from Sept 4, 1922, to Oct 22, 1923, that I last saw h.. alive on Oct 20, 1923, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Coronary disease

Pneumonia Gastritis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Unknown

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Joseph L Valentine, M. D.

Oct 22, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 23, 1923

20-UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80170

D 80170

CERTIFICATE OF DEATH.

46

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. McComas ST. 22 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Bromwell

(Residence in Baltimore: No. 211 W. McComas St.; 16 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 24 (Day) 1884 (Year)

7-AGE, 39 yrs. 4 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John W. Hartman

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Elizabeth Sebra

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible] M.D.

(Address) 2202 W. North

15-

OCT 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Filed ..... 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 20 (Day) 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-2- 1923, to 10-20 1923, that I saw h[illegible] alive on 10-20 1923, and that death occurred, on the date stated above, at 8.05 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to liver & intestines (Duration) [illegible] yrs. 6 mos. ds.

(Signed) [illegible] M. D.

10-21-, 1923 (Address) 2202 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 10-23-, 1923

20-UNDERTAKER [illegible]

ADDRESS 1318 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

D 80171

CERTIFICATE OF DEATH.

86 D 80171

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Joseph Hospital WARD)

2-FULL NAME Stephen Butler

(a) RESIDENCE NO. 1309 Riverside ST., Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 16, 1917

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or min.
	10	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward J Butler

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Dunsmyer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore

14 Informant Mrs Dunsmyer
(Address) 1309 Riverside

15 Filed OCT 23 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19th 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1923, to Oct 19th 1923.

that I last saw him alive on Oct 19, 1923,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

.....

.....

.....

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 17, '23

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Monninger M. D.

10-20, 1923 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	10/23/1923
20 UNDERTAKER	ADDRESS
J & J Fahey Sons	318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80172

CERTIFICATE OF DEATH.

1923 D 80172

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital 18 ST.) (COUNTY OF BALTIMORE)

2-FULL NAME Frances A. Ryan.

(a) RESIDENCE No 1110 W. Mulberry St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed or divorced
(or) WIFE of George E. Ryan.

6 DATE OF BIRTH (month, day, and year) February 14, 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER James B. Price.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Alice Cecil.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Eva Boenning. (sister)
(Address) 637 Hanover St.

15 Filed ....., 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.
OCT 23 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart and oedema of the lungs, brought on by a series of assaults. Homicide.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Oct. 22, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Assault 1110 W. Mulberry St. 10/19/23.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 23 1923

20 UNDERTAKER F. A. Pfau & Son ADDRESS 763 Hanover St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80173

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Adams

(a) Residence No. 439 W. Henrietta st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1907

7-AGE. 16 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 0 10

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Charles Adams

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Gertrude Fletcher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Hospital records

(Address) M.T.H.

13- Filed OCT 23 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 19 23 to Oct. 21 19 23

that I last saw h. im alive on Oct. 21 19 23

and that death occurred, on the date stated above, at 8.40 p.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes (autopsy.

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L-A-Lahey M. D

10-22. 19 23 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Zion ct	Oct 24 19 23
20-UNDERTAKER. C. E. Brown & Son	ADDRESS 1611 W. Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 80174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Fremont ST., 21 WARD)

2-FULL NAME James R. Dosson

(a) RESIDENCE No. 224 S. Fremont ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	—	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown —

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country)

12 MAIDEN NAME OF MOTHER — Wilson

13 BIRTHPLACE OF MOTHER unknown (city or town) ..... (State or country)

14 Informant James Dosson (Address) 224 S. Fremont

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

OCT 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1923, to Oct. 21, 1923, that I last saw him alive on Oct. 9, 1923, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea + Enteritis

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan Swanson M. D.

Oct. 23, 1923 (Address) 322 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Ct DATE OF BURIAL Oct 24 1923

20 UNDERTAKER S. E. Brown & Son ADDRESS 1015 W. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80175 — 91-09 — D 80175

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 E Eager ST., 10 WARD)

2-FULL NAME Henry Kroeger (Kroeger)

(a) RESIDENCE No. 1308 E Eager ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? 41 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Kunigunda Kroeger

6 DATE OF BIRTH (month, day, and year) Dec. 23 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Kunigunda Kroeger
(Address) 1308 E Eager St

15 Filed ..... 19 ..... Registrar

OCT 23 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18th 23 to Oct 21st 23

that I last saw h[illegible] alive on Oct 20th 23

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Cerebro spinal Syphilis

(duration) ... yrs. — mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) R. W. Roder, M. D.

Oct 22 19 23 (Address) 1308 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct. 24 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80176

CERTIFICATE OF DEATH.

113 D 80176

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5403 Harford Road ST., (Hamilton) 27 WARD)

2-FULL NAME Melvin. St. J. Stricker

(a) RESIDENCE NO. 5403 Harford Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Melvin. St. Stricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER M. Camilla Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. Melvin St. Stricker
(Address) 5403 Harford Road

15 Filed OCT 23 1923 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June. 15th. 1923 to Oct. 23 1923.
that I last saw him alive on Oct. 23 1923
and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cutreitis. } Contributory
anaemia. }

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Mal-nutrition.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thos. H. Maynard, M. D.

19 (Address) 14 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 24 1923
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 80177

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 E 38 St ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Baker

(a) RESIDENCE No. 510 E 38 St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years 59 Months Days If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs John J Myers

(Address) 510 E 38th St

15 Filed OCT 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-1923

17

I HEREBY CERTIFY, That I attended deceased from May 15 , 1923 , to Oct. 21 , 1923 ,

that I last saw her alive on Oct. 21 , 1923

and that death occurred, on the date stated above, at 7-10 P m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cancer cells

(Signed) J. Herman Hoffman M. D.

, 19 (Address) 1809 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL 10/24 1923

20 UNDERTAKER Temple Funeral Parlors ADDRESS Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 80178

HEALTH DEPARTMENT—CITY OF BALTIMORE

14-091 80178

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 William ST. 22 WARD)

2-FULL NAME William H. Boone

(a) RESIDENCE NO. 834 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Ella A Boone

6 DATE OF BIRTH (month, day, and year) Mar 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) G & W

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Ella A Boone (Wife) 834 William St

15 Filed OCT 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Oct 22, 1923

that I last saw him alive on Oct 21, 1923,

and that death occurred, on the date stated above, at 6.20 Am.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Atheroma from history (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Gorsuch M. D.

10, 23, 1923 (Address) 3100 Hoffman Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 24 1923

20 UNDERTAKER John P. Denny — ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80179

CERTIFICATE OF DEATH.

57 D 80179

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 9 WARD)

2-FULL NAME Rebecca Mericaw

(a) RESIDENCE NO. 2530 Hartford Ave

(Usual place of abode) WARD

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jacob Merisan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A Merisan

(Address) 3300 Beechard

15 Filed OCT 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1923, to October 23, 1923,

that I last saw her alive on October 23, 1923,

and that death occurred, on the date stated above, at 1.37 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) (duration) Myocarditis; yrs. mos 4 ds. Enterocolitis; Diabetes Mellitus

(duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidore L Frey, M. D.

10/23 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Co

DATE OF BURIAL 10/24 1923

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 80180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 1647

City of BALTIMORE: (No. 50 Rasp ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henry Mills

(a) Residence No. 50 Raspe Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A Mills

6-DATE OF BIRTH (month, day and year) Dec 8 1833

7-AGE, 89 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore.

PARENTS

10-NAME OF FATHER, Wm Mills.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Eliza Atkinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

11- (Informant) Joseph Mills

(Address) 60 N Payson St.

15- Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 22 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1923 to Oct 22 1923

that I last saw h. alive on Oct 21 1923

and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Old Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eustace A Sutton M. D.

10/25 1923 (Address) Overlea, Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood Cemetery

DATE OF BURIAL, Oct 25 1923

20-UNDERTAKER, H M Routson

ADDRESS 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80181

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1730 Lancaster St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Minnie Brill

(a) Residence No.... 1730 Lancaster St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: William Brill

6-DATE OF BIRTH (month, day and year): Nov. 30, 1880

7-AGE: 42 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town): Balto

(State or Country): Md.

PARENTS.

10-NAME OF FATHER: Wm. Friedeman

11-BIRTHPLACE OF FATHER (city or town): (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Annie Meier

13-BIRTHPLACE OF MOTHER (city or town): Balto (State or Country): Md.

11-

(Informant): William Brill

(Address): 1730 Lancaster St

15-

Filed ..... 192.... Registrar.

OCT 23 1923 ROBT. R. MAGRUDER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 17, 1923 to Oct 21, 1923.

that I last saw h...ative on Oct 20, 1923

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)....yrs....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Pearsons M. D.

10-22-23 19 (Address) 1m Hall

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Evangelical Luth. | DATE OF BURIAL: Oct 24, 1923

20-UNDERTAKER: H. Sander Sons | ADDRESS: 1710 Pleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1803

D 80182

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8 WARD)

2-FULL NAME Eli Vernon Brown Jr.

(a) RESIDENCE NO 1438 N. Broadway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) March 9/1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Eli V. Brown Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Cassandra Long

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14
Informant Eli V. Brown
(Address) 1438 N. Broadway

15
Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- Crushed abdomen& rt thigh
Strick by autotruck -accident

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Collins, M. D.
(Coroner.)
10/23/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 23 1923

20 UNDERTAKER Robt J Turner Sons — ADDRESS 1442 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 80183 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80183

X 129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hosp. 17
CITY OF BALTIMORE, No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel W. Anderson.

(a) RESIDENCE No. 1220 Etting ST., ... WARD ..... Candler Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Laura Anderson

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Reisterstown Carroll Co Md.

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Simms

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Charles S Anderson Son
(Address) Mt Airy Md.

15 Filed OCT 23 1923 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1923, to Oct 22, 1923, that I last saw alive on Oct 22, 1923, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John A. Schenck, M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion M E Ch Carroll Co Md. DATE OF BURIAL Oct. 25 1923

20 UNDERTAKER Wm J Hartwell ADDRESS 2234 W. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80184

D 80184

D 80184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1280

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) 914 N. Calhoun ST., 16 WARD)

2-FULL NAME Herman Laurence

(a) RESIDENCE NO. 914 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40 yrs.	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Denis Laurence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bessie Cook
(Address) 914 N. Calhoun St.

15 Filed ..., 192 ... Registrar

OCT 23 1923 PHILIP R. KRAUTH DEPUTY REGISTRAR OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said —do— (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute pneumonia
Streptococcus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. E. T. Hennessy, M. D. (Coroner.)

Oct. 22 1923 (Address) 2802 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Oct 23 1923
20 UNDERTAKER Sam'l. T. Chase Inc	ADDRESS 1405 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80185

CERTIFICATE OF DEATH.

129 D 80185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1714 Woodyear St. (Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Plater

(a) RESIDENCE No. 1714 Woodyear St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~ Sadie Plater

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) C a a. Co Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant John Richardson

(Address) 1714 Woodyear St

15 Filed OCT 23 1923 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Oct 19, 1923, that I last saw him alive on Oct 17, 1923, and that death occurred, on the date stated above, at 11-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey M. D.

10/24, 1923 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lucas	Oct 23 1923
20 UNDERTAKER	ADDRESS
Thos. W. Chase Inc	1708 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80186 Fulton Strt

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 80186

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Block Col. Ave ST., 16 WARD)

2-FULL NAME James S. Bucy

(a) RESIDENCE No. 2902 W. Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah L. Bucy (nee Gleaves)

6 DATE OF BIRTH (month, day, and year) Oct 23, 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baggage master
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R
(c) Name of employer

9 BIRTHPLACE (city or town) Flintstone
(State or country) Md

PARENTS

10 NAME OF FATHER Clinton Bucy

11 BIRTHPLACE OF FATHER (city or town) Flintstone
(State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Woolford

13 BIRTHPLACE OF MOTHER (city or town) Flintstone
(State or country) Md

14 Informant Mrs Geo Metz
(Address) 157 Washington Blvd

15 Filed OCT 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 6 hrs ds.

(Signed) Geo Milton Ball, M. D.
(Coroner.)

1923 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 23 1923
20 UNDERTAKER Harry Hilbelke	ADDRESS 1631 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117 D 80187

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norval R. Thompson

(a) RESIDENCE NO. Aberdeen Md ST., WARD Aberdeen Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Helen Wells Thompson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: ? Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Dr. Harry E. Osborn

(Address) 1320 N. Charles St

15 Filed OCT 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1923.

17

I HEREBY CERTIFY, That I attended deceased from October 15, 1923, to Oct 23, 1923,

that I last saw him alive on Oct 23, 1923

and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Acute Peritonitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 16-1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Chesnutt, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md

DATE OF BURIAL: Oct 23 1923

20 UNDERTAKER: Wm Flickner Sons

ADDRESS: North Ave

Spec—12-23-21—E.B.R.S.—400 Bks. Helen Schweizer.

D 80188 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 31 D 80188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 506 S. Rose St. 1 St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Schweizer

(a) Residence No. 506 S. Rose St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Stewart Schweizer

6-DATE OF BIRTH (month, day and year): Jan. 28, 1900

7-AGE: 23 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: William Valuch

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Katherine Dubinski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

11-(Informant): Stwart Schweizer Husband

(Address): 506 S. Rose St.

15-Filed ..... 193.... ROBERT R. KRAUTER, Registrar.

OCT 23 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 21-1923.

17- I HEREBY CERTIFY, That I attended deceased from October 20, 1923 to Oct. 21, 1923

that I last saw her alive on Oct. 21 1923

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Edema and Intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute cardiac Dropsy.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Kuntzsch M. D

. 19 (Address) 1629 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Oct 27 1923

20-UNDERTAKER: W. J. Sadowski — ADDRESS: 705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80189 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 101-001 ✓ D 80189

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Fait Ave ST., 1 WARD)

2-FULL NAME Frank Cichocki

(a) RESIDENCE NO. 2616 Fait Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Gustie Cichocki

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Bolcer Cichocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Johanna Wisolowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Gustie Cichocki.

(Address) 2616 Fait ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1923, to Oct 21, 1923.

that I last saw him alive on Oct 20, 1923

and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Neer, M. D.

(Address) 402 Fait Ave

10/22/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 24 1923

20 UNDERTAKER M. F. Sadowski ADDRESS 705 Shan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 23 1923 ROBERT R. KRAUTER, DEPUTY REGISTER OF WILLS

Spec.—1-10-21—M&T—1500 Bks.

D 80190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80190

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Colonial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 122 Work Mount ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Mason Hough

(a) RESIDENCE No. 611 West Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah M. Hough

6 DATE OF BIRTH (month, day, and year) Feb 15 1863

7 AGE 62 Years | Months | Days | If LESS than 1 day, hrs or min.

62

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Leesburg, Virginia.

PARENTS

10 NAME OF FATHER John Hough

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Regina Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio Town

14 Informant F. M. Ebert

(Address) 1713 West Lanvale

15 Filed OCT 23 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22 1923.

17

I HEREBY CERTIFY, That I attended deceased from September 23, 1923, to October 22, 1923.,

that I last saw him alive on October 22, 1923.,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds. 3

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. Robinson, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 25 1923

20 UNDERTAKER William Cook — ADDRESS 502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80191

CERTIFICATE OF DEATH.

74-001 D 80191

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1725 Hope St ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula L. Wess.

(a) RESIDENCE No. 1725 Hope St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Wess.

6 DATE OF BIRTH (month, day, and year): Nov 15th 1886

7 AGE: 37 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Fredrick List

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Hanken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: George. Wess. (Address) 1725 Hope St

15 Filed . 19 Robert P. Harrison Registrar

Burial Permit Clerk.

OCT 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1923, to Oct 21, 1923, that I last saw her alive on Oct 20, 1923, and that death occurred, on the date stated above, at 7th P. m.

The CAUSE OF DEATH* was as follows:

Hemaplegia Cerebal

1st stroke (duration) 2 yrs. last stroke mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebal Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. R. O. Carman M. D.

10 21 1923 (Address) 1707 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy. Redeemer.

DATE OF BURIAL: Oct 24th 23

20 UNDERTAKER: Leo D. Cook.

ADDRESS: Northwestern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... DEA... TION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

166/D 80192

HEALTH DEPARTMENT—CITY OF BALTIMORE D 80192

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Lund

(a) RESIDENCE NO. 127 N. Potomac ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of: Gustav Lund

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 45; Months ?; Days ?; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: John Stenton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Annie Carlson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant (Address): J.R.R. Records

15 Filed ..... 19 ..... Registrar

OCT 23 1923

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923 19 ..... to Oct 23 19 23

that I last saw her alive on Oct 23 19 23

and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis - Thrombo-phlebitis of intervertebrae

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Metastatic Lung Abscesses - Empyema (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R.R. Hannon, M. D.

Oct 23 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Oct 23, 1923.

20 UNDERTAKER: Martin W.E. Dipple ADDRESS: 37 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80193 D 80193

178

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 17 WARD)

2-FULL NAME Carmela Marsiglia

(a) RESIDENCE NO. 634 W. Franklin St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Marsiglia

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Marsiglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angela Scurto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Marsiglia
(Address) 634 W. Franklin St.

15 Filed OCT 23 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923 to Oct 21, 1923, that I last saw her alive on Oct 21, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia (post-partum)

(duration) .. yrs. mos 2 ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. G. Marino, M. D.

(Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL 10/24/23.

20 UNDERTAKER Geo. D. Ruth, ADDRESS 935 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-101.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 23 WARD)

2-FULL NAME Ferdinand Birchbauer

(a) RESIDENCE NO. 1709 Patapsco St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1880

7 AGE: Years 43 | Months 8 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Ferdinand

11 BIRTHPLACE OF FATHER (city or ~~town~~) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Rich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs. Birchbauer

(Address) 1709 Patapsco St.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to Oct 21, 1923, that I last saw him alive on Oct 21, 1923 and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Primary (pernicious) anaemia

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examinations

(Signed) R. R. Hannon, M. D.

10/22 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. a. a.

DATE OF BURIAL Oct 25 1923

20 UNDERTAKER Margaret & F. Flynn

ADDRESS 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80195

D 80195

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1268 Riverside Ave ST.; 24 WARD)

2-FULL NAME Florence Deems

(a) RESIDENCE. NO. 1268 Riverside Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earl Deems

6 DATE OF BIRTH (month, day, and year) Dec 7, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (Hd)

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jno. A. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Fannie E. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Mrs. E. M. Mark (Address) 1268 Riverside Ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Oct 20, 1923, that I last saw her alive on Oct 20, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy acute

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Burkett, M. D.

1923 1923 (Address) 1272 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Oct 24 1923
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 W. Fay

OCT 23 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80196

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 401 St Paul Place ST., 4 WARD)

2-FULL NAME Rev John A. Glancy

(a) RESIDENCE NO. 401 St Paul Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1870

7 AGE — Years: 53 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Priest 065

(b) General nature of industry, business, or establishment in which employed (or employer): Pastor St Rose R.C. Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thos J. Glancy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary A Gaffney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: A. S. Burns

(Address): Phila Pa

15 Filed OCT 23 1923, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21—1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Oct 21, 1923.

that I last saw h[illegible] alive on Oct 21st, 1923,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ½ hour ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Abs O'Donovan, M. D.

Oct 23, 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila Pa

DATE OF BURIAL: 10/24 1923

20 UNDERTAKER: Chas P. Evans & Son

ADDRESS: 118 West Royal Ave

(Burial Permit Clerk.)

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80197 — CERTIFICATE OF DEATH. — 113 — D 80197

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 104 W. Eager ST.; 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Allen Van Bergen

(Residence in Baltimore: No. 104 W. Eager St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1922 (Year)

7-AGE, 1 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bernard J. Van Bergen

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER, Mary E. Regan

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Van Bergen

(Address) 104 W. Eager St.

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

OCT 23 1923 Burial Permit C...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1923, to Oct 22 1923, that I saw him alive on Oct 21 1923, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 23, 1923. (Address) 5 S. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, 10/24, 1923

20-UNDERTAKER Chas. F. Evans & Son — ADDRESS 1181 Wm. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 80198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 425 E. North ave ST., 17 WARD)

2-FULL NAME Adderley Cooper

(a) RESIDENCE NO. 425 E. North ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Cooper

6 DATE OF BIRTH (month, day, and year) Unknown 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Sea Captain

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermuda

PARENTS

10 NAME OF FATHER Thos Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermuda

12 MAIDEN NAME OF MOTHER Elizabeth Newbold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant Minnie Cooper

(Address) 425 E. North ave

15 Filed ..... 19 .....

Registrar

OCT 23 1923

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 — 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Oct 21, 1923, that I last saw him alive on Oct 21, 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas L Goldsborough Jr M. D.

, 19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 10/24 1923

20 UNDERTAKER Chas R. Evans & Son

ADDRESS 118 W Mt Royal ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80199 123 D 80199

D 80199

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Sharp ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Garnett

(Residence in Baltimore: No. 706 Sharp St.; 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Tilly Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Hilliary

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Garnett

(Address) 706 Sharp St

15-

Filed ....., 191.....

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 4 1923, to October 21 1923, that I saw h Er alive on October 21 1923, and that death occurred, on the date stated above, at 9 30 p m.

The CAUSE OF DEATH* was as follows:

Violent Mania

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H S Ward M. D.

10/22 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, U S National Ct

DATE OF BURIAL, Oct 24, 191...

20-UNDERTAKER J. E. Brown's Son

ADDRESS 1015 W. Monroe

Spec.—1-10-21—M&T—1500 Bks.

D 80200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 ✓ D 80200

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Spring ST., 9 WARD)

2-FULL NAME Baby Stewart

(a) RESIDENCE NO. 1819 N. Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 40 min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Tazlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hattie Stewart

(Address) 1819 Spring St Baltimore Md

15 Filed OCT 24 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1923. to Oct. 20, 1923.

that I last saw him alive on Oct. 19, 1923,

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis
Congenitas.

(duration) ..... yrs. mos ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. E. Duncan M. D.

1920, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health,

ADDRESS: Oct 23 1923

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80201

46

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Fuller

Born -

(a) RESIDENCE NO. 1108 Bone Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Daughter, Jane Fuller
(Address) 1108 Bone Alley

15 Filed OCT 24 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1923, to Oct. 21, 1923,

that I last saw h.. alive on October 20, 1923,

and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and hypertension
Generalized carcinomatosis &
abdomen primary in ovary (probably)

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, left.

(duration) c yrs. c mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of /

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harry E. Handley, M. D.

, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 27th 19 23
20 UNDERTAKER E. C. Jones	ADDRESS 1161 Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dorsin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80202

D 80202

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Jenkins Alley St. 11 WARD)

2-FULL NAME Emma Dorsin

(a) RESIDENCE. No. 1013 Jenkins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. — ds. —How long in U. S., if of foreign birth? yrs mos ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband unknown

6 DATE OF BIRTH (month, day, and year) Aug 22 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
S	52	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm C. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Tillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Beatrice Taylor
(Address) 1813 Jenkins Ave

15 Filed OCT 24 1923 19 ROBERT P. KRANTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1923. to Oct. 23. 1923.
that I last saw her alive on Oct. 22 . 1923.
and that death occurred, on the date stated above, at 12:15a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (est confirmed diagnosis?

(Signed) H. C. Petterson . M. D.

. 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Oct 25 1923
20 UNDERTAKER J. Fron Hall	ADDRESS 753 Dolphin St

D 80203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80203

CERTIFICATE OF DEATH.

181-007

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1427 Ward St ST.: 21 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley Vaughan

(Residence in Baltimore: No. 1427 Ward St

St.; yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Oct 21 1923
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work. Regular
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. Robert Vaughn

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Mildred Conway

13-BIRTHPLACE OF MOTHER (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Vaughn

(Address) 1427 Ward St.

15-

Filed OCT 24 1923, 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. 22, 19..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxia

(Duration) ....yrs. ....mos. 1 hr.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Edwin Blake M. D.
(Coroner)

Oct 22 1923 (Address) 143 N Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Bloomfield

DATE OF BURIAL Oct 24 1923

20-UNDERTAKER Barnes & Leyhe

ADDRESS 1536 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 80204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 80204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Erck

(a) RESIDENCE No. 602 No. Broadway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Erck Jr

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER John Walz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo Erck

(Address) 602 N Broadway

15 Filed , 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9th, 1923, to Oct 20th, 1923, that I last saw her alive on Oct 20th, 1923, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Postperitoneal tumor behind stomach (duration) 5 mo. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10-10-23

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Monninger M. D.

Oct 20 1923 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct 24 1923

20 UNDERTAKER John Meerios

ADDRESS 208 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80205

CERTIFICATE OF DEATH.

31 D 80205

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. 12th ST., No. WARD)

2-FULL NAME Ida Arnold

(a) RESIDENCE NO. 711 S. 12th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Rudolph Arnold

6 DATE OF BIRTH (month, day, and year): Sept 12-1893

7 AGE: Years 30 | Months — | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank Cook.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Ida Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Rudolph Arnold

(Address): 711 S. 12th St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Oct 21, 1923, that I last saw h[illegible] alive on Oct 21, 1923, and that death occurred, on the date stated above, at 8 [illegible]

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John B. Owens, M. D.

Oct 22, 1923 (Address) 35-N Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Oct 24 1923

20 UNDERTAKER: John Merrick

ADDRESS: 2308 Eastern

ROBERT P. KRAUTZ
BURIAL PERMIT CLERK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80206

CERTIFICATE OF DEATH.

129 D 80206

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4709 Eastern Ave ST., No WARD)

2-FULL NAME Frederick A. Hilse

(a) RESIDENCE No. 4709 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Hilse

6 DATE OF BIRTH (month, day, and year) 12/21/1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hilse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Hilse (Address) 4709 Eastern Ave

15 Filed . . . . 19 Registrar

OCT 24 1923 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23/1923

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to Oct 23, 1923, that I last saw him alive on Oct 23, 1923, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.

10/24 1923 (Address) 701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Oct 25 1923

20 UNDERTAKER John Zellers

ADDRESS 2008 Bleecker

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80207

CERTIFICATE OF DEATH.

90

D 80207

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 Tarrant ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Jones

(a) RESIDENCE. No. 308 Tarrant ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Perrin Diggs (Address) 308 Tarrant St.

15 Filed OCT 24 1923, 19__ ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Oct. 21, 1923, that I last saw him alive on Oct. 21, 1923, and that death occurred, on the date stated above, at 3-15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

10-24 1923 (Address) 120 Ashgrove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 24 1923

20 UNDERTAKER Mrs. Chas B. Jones ADDRESS 1725 Eastlake

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80208

REGISTERED NO. 1590

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1862 Rosedale St. 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolly A Pilchard

(a) RESIDENCE. No. 1862 Rosedale St., 15 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced~~ (write word): Widow

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~: The late Peter T Pilchard

6 DATE OF BIRTH (month, day, and year): Feb 4 40

7 AGE: Years 82 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Riggin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Worcester Co Md

12 MAIDEN NAME OF MOTHER: Nick Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs Lilly Huggins

(Address): 1862 Rosedale St.

15 Filed . 19 .Registrar

OCT 24 1923 ROBERT R. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Oct 21, 1923.

that I last saw her alive on Oct 21, 1923.

and that death occurred, on the date stated above, at 9.16 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Age - Dilated Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Starkey M. D

Maryland

, 19 (Address) 3043 W 31st St Md Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Park Cem

DATE OF BURIAL: Oct 24 1923

20 UNDERTAKER: W M Routson

ADDRESS: 2235 W Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80209

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Agnes Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah E. Keyes

(a) RESIDENCE No. 1338 Saugent St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alison Keyes.

6 DATE OF BIRTH (month, day, and year) May 9, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	—	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Fishbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha E. Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Margaret Frey

(Address) 315 Md Ave Westfield Md

15 Filed OCT 24 1923, 19 Registrar ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 6 1923 to Oct 23 1923

that I last saw her alive on Oct 23 1923

and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

Carcinoma of Stomach (?)

8

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Lab

What test confirmed diagnosis?

(Signed) H V Harper, M. D.

(Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md. Ashury Cem DATE OF BURIAL Oct 25 1923

20 UNDERTAKER Mr & Mrs John W. Tempel & Son ADDRESS 801 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 80210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80210

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1609 Friendsbury ST. 15 WARD)

2-FULL NAME Amelia E. Funk.

(a) RESIDENCE No. 1609 Friendsbury ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of John J. Funk.

6 DATE OF BIRTH (month, day, and year) April 13, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	70.	6.	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) ~~John Knapp~~ 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Knapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Knapp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John J. Funk. (Address) 1609 Friendsbury St.

15 Filed ..... 19 ..... Registrar

OCT 24 1923 ROBERT P. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24 , 1923, to Oct. 22 , 1923, that I last saw h- alive on Oct. 22 , 1923, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) — yrs, mos 6 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) James Brown, M. D.

10/23 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL Oct. 25. 1923

20 UNDERTAKER Wm. & Jno. H. Penfold & Son

ADDRESS 801 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80211

CERTIFICATE OF DEATH.

74-001

D 80211

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. *AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 W. Hamburg ST. 21 WARD)

2-FULL NAME Dora B. Kramer

(a) RESIDENCE NO. 739 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Kramer

6 DATE OF BIRTH (month, day, and year) May 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	71	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Va

PARENTS

10 NAME OF FATHER Jacob Byer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jos. Kramer 739 W. Hamburg st

15 Filed OCT 24 1923 ROBERT R. KRAUSER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1923 to Oct 22 1923

that I last saw h alive on Aug 31 1923

and that death occurred, on the date stated above, at 5 05 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Schwensberg M. D.

, 19 (Address) 1126 Wilson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct. 24 1923.

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S Paca St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80212

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Josephs Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert C. Stewart

(a) Residence No. 437 N. Calvert St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leah R. Stewart

6-DATE OF BIRTH (month, day and year) April 25, 1878

7-AGE, 45 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Pittsburg (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Robert Stewart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Eliza Jane Haslett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) James Logan Stewart
(Address) 0220 Wilkens Ave.

15- Filed OCT 24 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1923, to Oct 22nd 1923 that I last saw h in live on Oct 22, 1923 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Liver Abscess

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Monninger M. D.

10-23, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Oct. 24, 1923

20-UNDERTAKER, Joseph B. Todd ADDRESS 1003 N. Gilmor St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Brierly)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80213

CERTIFICATE OF DEATH.

74-001

D 80213

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 707 Ramsay ... ST., 21 ... WARD)

2-FULL NAME Jacob S. Brierly

(a) RESIDENCE NO. 707 Ramsay ... ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER W. C. Brierly

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Hornsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant M. J. Brierly
(Address) 738 N. Fulton Ave

15 Filed OCT 24 1923 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) ... yrs. ... mos. ... ds.

(Signed) ... , M. D.
(Coroner.)
..., 192 ... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Oct 25 1923

20 UNDERTAKER Joseph L. Bork ADDRESS 1003 N. Bath St

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Massaroni) ✓

D 80214

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

D 80214

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3716 Fait Avenue St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Angelo Massaroni

(a) Residence No. 3716 Fait Avenue St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 7½ ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1-27-23

7-AGE. ..... yrs. 8 mos. 7½ ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS

10-NAME OF FATHER, Michael Massaroni

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Marie Massaroni

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Michael Massaroni

(Address) 3716 Fait Ave. City

15- Filed ....., 192.... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 23. 1923

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1923 to Oct. 23, 1923

that I last saw him alive on Oct. 22 1923

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

+ Intoxication

(Duration) ..... yrs. ..... mos. ✓ ..... ds

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. J. Marr M. D

Oct. 24. 1923 (Address) 801 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 25, 1923
20-UNDERTAKER, J. Falkenstein	ADDRESS 1st & Bond St

Spec.—1-10-21—M&T—1500 Bks.

D 80215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80215

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Homewood Ave ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Evelina Smith

(a) RESIDENCE NO. 1210 Homewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 8, 1860

7 AGE: Years 63 Months 6 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Benj Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E. Neale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Aloysius Smith

(Address) 1210 Homewood Ave

15 Filed OCT 24 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to Oct 23, 1923,

that I last saw her alive on Oct 22, 1923,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Oedema lungs following Cardiac dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebro-vascular disease

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward, M. D.

10/24/23 (Address) 225 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Weidefeld — ADDRESS: 917 Fremont Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80216

CERTIFICATE OF DEATH.

11-002

D 80216

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E-Monument ST., 11 WARD)

2-FULL NAME Esther Dannenberg

(a) RESIDENCE No. 232 Richman ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 23/21

7 AGE: Years 2 | Months 2 | Days — | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None old

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Abraham Dannenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fannie Gendis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Abraham Dannenberg. 232 Richman St

15 Filed OCT 24 1923 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-23 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/11, 1923, to 10/23, 1923, that I last saw h[illegible] alive on Oct. 23, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: Influenza Meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Fluid smear

(Signed) Rose Goldberg M. D.

Oct 24 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew M A Carmel — DATE OF BURIAL: Oct 24 1923

20 UNDERTAKER: May Funeral Home — ADDRESS 1127 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 80217

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Brown

(a) RESIDENCE. No. 1204 Mc Culloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Charles City Va

PARENTS

10 NAME OF FATHER Bill Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles City Va

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles City Va

14 Informant Thane Clabaun
(Address) 1209 Mc Culloh st

15 Filed . 19 Registrar

OCT 24 1923

ROBERT V. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Oct 23, 1923, that I last saw h[illegible] alive on Oct 23, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1204 Mc Culloh St

Did an operation precede death? Yes Date of Oct 22/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S B Hughes M. D.

Oct 24, 1923 (Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charles City Va	Oct 1923
20 UNDERTAKER	ADDRESS
John T. Owens	1538 Druid

Spec.—8-24-14—M. & T.—2000 Blks.

Simon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80218

CERTIFICATE OF DEATH.

14 74-001 D 80218

1-PLACE OF DEATH Park ave & Wilson St

CITY OF BALTIMORE: (No. The Plaza ST.: 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Simon

(Residence in Baltimore: No. The Plaza St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. July (Month) 8 (Day), 1827 (Year)

7-AGE. 96 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lodging House
(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Otto Sonney

11-BIRTHPLACE OF FATHER (State or Country). Berlin Germany

12-MAIDEN NAME OF MOTHER Elizabeth Kauderer

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis A. Simon

(Address) Plaza apt

15-

Filed ..... 191.....

OCT 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October (Month) 23 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1923, to Oct 23 1923, that I saw h[illegible] alive on Oct. 23 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Charles Bell M. D.

Oct 23, 1923 (Address) 1320 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem

DATE OF BURIAL. 10-26-1923

20-UNDERTAKER. Henry W. Justice & Son Co

ADDRESS McCulloh Orchard St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80219

CERTIFICATE OF DEATH.

113

D 80219

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 East Preston ST., 11 WARD)

2-FULL NAME Francis Xavier Meredith.

(a) RESIDENCE NO. 416 East Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Mch 15, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	----------	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer ----------

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Ernest Meredith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A Fahey.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mrs Mary A Meredith.
(Address) 416 East Preston Ave

15 Filed 10/24/1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/16/23, 19 . to 10/23/23, 19 .

that I last saw him alive on 10/23/23, 19 ;

and that death occurred, on the date stated above, at 1225 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Union Memorial Hosp

Did an operation precede death? No. Date of 10/15/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

10/24/23 19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery. DATE OF BURIAL: 10-25 19 23

20 UNDERTAKER: Henry W Mears & Son, ADDRESS: 805 N Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80220

CERTIFICATE OF DEATH.

31 D 80220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3307 Piedmont Ave (St.) 15 (Ward)

2-FULL NAME Frances B. McDonagh.

(a) RESIDENCE. No. 3307 Piedmont Ave St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Martin P. McDonagh

6 DATE OF BIRTH (month, day, and year) Aug 11. 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Henry Bruns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Martin P. McDonagh

(Address) 3307 Piedmont Ave

15 Filed OCT 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1923 to Oct 23 1923,

that I last saw her alive on Oct 22 1923.

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown — — —
(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. E. Conser, M. D.

10/23 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 25 1923
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2175 Pac

Spec.—1-10-21—M&T—1500 Bks.

12 D 80221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 80221

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Eutaw Place ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Fenton Kerr

(a) RESIDENCE NO. 1211 Eutaw Place ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? 60 yrs. 9 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kerr

6 DATE OF BIRTH (month, day, and year) Feby-15-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Aaron Fenton

11 BIRTHPLACE OF FATHER (city or town) Washington Co. (State or country) Penna

12 MAIDEN NAME OF MOTHER Rebecca Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mr. Norman Fenton

(Address) 172 Bolton St.

15 Filed OCT 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1921, to 10/22, 1923, that I last saw h[illegible] alive on 10/22, 1923, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder

of Vagina (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of early in 1921

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory findings

(Signed) [illegible], M. D.

10/23 1923 (Address) 1403 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery DATE OF BURIAL Oct 25 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT record. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D 80222

CERTIFICATE OF DEATH.

23 D 80222

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Ellamont ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Richardson

(a) RESIDENCE NO. 2407 Ellamont ST., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? 69 yrs. 3 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July-13-1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Beale St. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Stanford Co Md.

12 MAIDEN NAME OF MOTHER: Catherine Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs G Warfield Hobbs (nee)

(Address) 2407 Ellamont St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923 to Oct 23 1923, that I last saw h e alive on Oct 22 1923, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary): Paralysis Agitans

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms

(Signed) John A Cash, M. D.

19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Oct 25 1923

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE[cord]. mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex[amination] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80223 ✓ 51 D 80223

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Wiconico ST., 21 WARD)

2-FULL NAME Harry J. Muench

(a) RESIDENCE NO. 1125 Wiconico ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, ~~widowed, or divorced~~ (or) ~~WIFE of~~ Florence Muench

6 DATE OF BIRTH (month, day, and year) Mar 28/81

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House painter

(b) General nature of industry, business, or establishment in which employed (or employer) painting 050

(c) Name of employer don't know

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis H. Muench

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Carl

13 BIRTHPLACE OF MOTHER (city or town) Chambersburg
(State or country) Pa.

14 Informant Emma L. Mitchell
(Address) 1121 Carlton St.

15 Filed ....., 19..... Robert F. Harrison Registrar

OCT 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923, to Oct 23, 1923, that I last saw h~~im~~ alive on Oct 22, 1923 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) about yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) 0 yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Maryland Gen

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H C Krumbhaar, M. D.

Oct 23, 1923 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 26 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. Lt. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80224 ✓ 74-00 D 80224

D 80224

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6000 Belloma Av. St., 27 WARD)

2-FULL NAME Sarah Elizabeth Weller

(a) RESIDENCE NO. 6000 Belloma Av St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev Addison Weller

6 DATE OF BIRTH (month, day, and year) May 5 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Eli Keeran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Pinkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. E. Carter (Address) 6000 Belloma Av

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Oct 23, 1923, that I last saw her alive on Oct 22, 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Paralysis right side
Dr Wood

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. H. Duncan, M. D.

Oct 23 1923 (Address) 5136 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 25 1923

20 UNDERTAKER Tom Cook ADDRESS 5525 Harford

OCT 24 1923
Robert P. Harrison,
Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D 80225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80225

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3105 N. Charles ST., 12 WARD)

2-FULL NAME Alphonso O. Wolseley

(a) RESIDENCE NO. 3105 N. Charles ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Dorothy Wolseley

6 DATE OF BIRTH (month, day, and year) Dec 4, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales manager

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer Tri Reduction Sales Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Wolseley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Estella King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dorothy Wolseley

(Address) 3105 N. Charles St

15 Filed OCT 24 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 19 to Oct 23, 19 23;

that I last saw him alive on Oct 23, 19 23

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) — yrs. 18 mos — ds.

CONTRIBUTORY (Secondary) — (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis Blood picture

(Signed) W. W. Mayo, M. D.

Oct. 1923 (Address) Baltimore - Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Wm Cook & Son E — ADDRESS: Town

WARNING—REGISTERED UNDER THE LAWS OF MARYLAND. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 24 1923

Issued Permit Clerk

D 80226 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Emerson Ave Apts 13 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Laufheimer

(Residence in Baltimore: No. Emerson Ave Apts 13 St.; yrs. mos. ds.)

Balto City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: July 21 (Month) (Day) 1859 (Year)

7-AGE: 64 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Mfr
(b) General nature of Industry, business, or establishment in which employed (or employer): Manufacturer

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Fred. Laufheimer

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Matilda J.

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE ENTRIES TO THE BEST OF MY KNOWLEDGE.

(Informant) Willard Laufheimer

(Address) Emerson Ave Apts

15-

Filed ..... 192.....

Registrar.

CT 24 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dwight Mowell M. D. (Coroner)

Oct 23 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	10/25/ 1923
20-UNDERTAKER,	ADDRESS
David Sondheim	118 W. Mt. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 80227

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1422 Hollins St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Jose

(a) Residence No. 1422 Hollins St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 11, 1840

7-AGE. 82 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ludwig Jose

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-

(Informant) Mary E. Steele

(Address) 1422 Hollins St.

15-

Filed OCT 24 1923, 19

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 24 - 23

17-I HEREBY CERTIFY, That I attended deceased from One visit Oct 23, 1923, to, 19

that I last saw h[illegible] alive on Oct 23, 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) some years yrs. mos. ds.

CONTRIBUTORY (Secondary) Advanced age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D

Oct 24, 1923 (Address) 1929 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loretto [illegible]	Oct 25 19
20-UNDERTAKER, George J Smith	ADDRESS 1532 Hollins

Robert P. Harrison

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80228

188-003

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 W. Pratt ST., 19 WARD)

2-FULL NAME George Allman

(a) RESIDENCE NO. 1516 W. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 28, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mtn.
	7			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robt L. Allman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Rose Mortkem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Mrs Allman
(Address) 645 Gutman Ave

15 Filed ....., 192 ..... Registrar Robert P. Harrison, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto-Accident

Fracture Skull.

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Slack.

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Geo Clinton Bladen M. D.
(Coroner)

Oct 24 1923 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 25 1923
UNDERTAKER Harry N. Witzke	ADDRESS 1531 W. Lombard St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Blks.

D 80229

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

X 57 D 80229

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) Calvert & Saratoga STS. 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tyler

(a) RESIDENCE No. Hastings, Penna. ST. ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. One mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/14/51

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer.

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hastings Penna.

PARENTS

10 NAME OF FATHER Henry Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Hospital Records.

15 Filed OCT 25 1923 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/1923

17 I HEREBY CERTIFY, That I attended deceased from 8/29, 1923, to 10/24, 1923, that I last saw him alive on 10/24, 1923, and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus - Diabetic Gangrene - Nephritis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 15 Min.

18 Where was disease contracted if not at place of death? Penna.

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Examination

(Signed) K. W. Galley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hastings Penna

DATE OF BURIAL 10/26 1923

20 UNDERTAKER Geyle & Finley Sultana

ADDRESS Fayette

Spec.—8-24-14—M. & T.—2000 Blks.

D 80230 HEALTH DEPARTMENT—CITY OF BALTIMORE D/80230

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maternity ST. 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant son of David D. Davis

Address of parents

(Residence in Baltimore: No. 2076 Aiken - In maternity St.; ....yrs., ...mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH Oct. 20th, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) X

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, David D. Davis

11-BIRTHPLACE OF FATHER (State or Country), South Carolina.

12-MAIDEN NAME OF MOTHER Mary Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David D. Davis

(Address) 2076 Aiken St

15- Filed OCT 25 1923, 19..... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 24th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20th 1923, to Oct. 24 1923, that I saw h[illegible] alive on Oct. 23 1923, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows: death was sudden as stated
Heart Trouble as assigned
Contributory Prematurity (Duration) ....yrs. ....mos. 10 minutes ds.

CONTRIBUTORY X (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

10-24-, 1923 (Address) 54 [illegible] Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. X mos. 4 ds. In the State + yrs. + mos. 4 ds.

Where was disease contracted, if not at place of death? X

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cem	10 25, 1923
20-UNDERTAKER Robert Brooks & Son	ADDRESS Cathedral & Mulberry Sts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 80231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80231

46

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington ST. Vol of America Hosp. WARD)

2-FULL NAME Mrs. Sarah N. Brooks 17

(a) RESIDENCE. NO. 2148 E 20th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm H. Brooks.

6 DATE OF BIRTH (month, day, and year) SEPT. 2 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER G. Helmling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Sofia Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Lil Levy

(Address) 441 E. 20th St

15 Filed . 19 . Registrar

Burial Permit Clerk. OCT 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 24, 1923, that I last saw her alive on Oct 24, 1923, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of abdomen possibly beginning in right Fallopian tube.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinomatous cachexia

Myocarditis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 13, 1923

Was there an autopsy? no.

What test confirmed diagnosis? Laparotomy & Section

(Signed) Edward L. Johnson M. D.

, 19 (Address) 1717 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem.	Oct 26 1923
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins sts

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80232

D 80232

111-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Carrie White

(a) RESIDENCE No. 204 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Fifty yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Unkn.

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: 41 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER William White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do Baltimore

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

15 Filed OCT 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Octob 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Octob 19, 1923, to Octob 21, 1923, that I last saw her alive on Octob 21, 1923, and that death occurred, on the date stated above, at 12 10 p. m.

The CAUSE OF DEATH* was as follows:

Perforated Pyloric Ulcer

Unkn. (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

Unkn. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) N. McDonnell M. D.

10/25/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Cemetery — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Eastland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 80233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80233

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No.....St.,.....Ward) Municipal Tuberculosis Hospital 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Thompson (Thomas)

(a) Residence No. Melvale School St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1907

7-AGE: 16 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School-girl
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS:
10-NAME OF FATHER: George Thompson
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Addie Mitchell
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

11-Informant: Hospital Records
(Address): M.T.H.

15-Filed OCT 25 1923 192 ROBERT N. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1922 to Oct. 21 1923
that I last saw h.er alive on Oct. 21 1923
and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally, M. D.
10-22-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: 10-26-23

20-UNDERTAKER: Rud. Carter ADDRESS 916 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80234

CERTIFICATE OF DEATH.

32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Raborg ST., 4 WARD)

2-FULL NAME Clarence Raymond Rundall

(a) RESIDENCE NO. 716 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 3-1922

7 AGE: Years: 1 Months: Days: 23. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ppo

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jno. Rundall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Nora Denbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md,

14 Informant: Jno Randall

(Address): 716 Raborg

15 Filed OCT 25 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-23-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Oct 23, 1923, that I last saw him alive on Oct 22, 1923, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Rodwell, M. D.

, 19 (Address) 739 Montpelier St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 10-25-1923

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80235

CERTIFICATE OF DEATH.

90 D 80235

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 W. Eldery ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Reggie

(a) RESIDENCE NO. 3017 W. Eldery ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of Geo. E Reggie

6 DATE OF BIRTH (month, day, and year) Oct. 12 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	70		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Henry Hetker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Louisa Lieel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Mrs. Geo. Reggie

(Address) 3017 W. Eldery St

15 Filed OCT 25 1923, 19 ..... Registrar

OCT 25 1923

RUDOLPH K. HAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1923, to Oct 23, 1923, that I last saw h-- alive on Oct 23, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown M. D.

10/23 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Robert L. Little — ADDRESS 2200 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80236

CERTIFICATE OF DEATH.

181-001 D 80236

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 So. Chester ST., V WARD)

2-FULL NAME Morris Flinkman

(a) RESIDENCE NO 126 So. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer) Odr
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Franz Flinkman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Bertha Perice

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Harry Flinkman
(Address) 1652 N. Fulton Ave

15 Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Asphyxiation by Illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Leaky Gas Tube

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. B. Horton, M. D.
(Coroner.)

Oct 24 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 10/24 1923

20 UNDERTAKER D. Levison & Bro

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 80237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 80237

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3405. Morton Ave ST. 28 WARD)

2-FULL NAME Sarah M. Byrne

(a) RESIDENCE NO. 3405. Morton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25 1874

7 AGE — Years: 49 — Months: — — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Forelady. 067

(b) General nature of industry, business, or establishment in which employed (or employer): Hutzler Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: Wallis J. Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Winifred Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Cath B. Byrne

(Address) 3405 Morton Ave.

15 Filed OCT 25 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1923 to Oct. 24, 1923

that I last saw her alive on Oct. 24, 1923

and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. M. Sorrell, M. D.

3705 (Address) Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Geo M. Frick & Son — ADDRESS: 811 W Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80238

Spec. Form No. 12 B. C. Co.—1000 Blks.

D 80238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 S. Luzerne ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Gertrude Washington Peterson

(a) RESIDENCE. NO. 941 S. Luzerne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 10 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard Washington

11 BIRTHPLACE OF FATHER (city or town) Somerset Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Canon

13 BIRTHPLACE OF MOTHER (city or town) Del
(State or country)

14 Informant Alice Washington
(Address) 941 S. Luzerne

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1923, to Oct 24, 1923 that I last saw h[illegible] alive on Oct 22, 1923 and that death occurred, on the date stated above, at 6.35 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) One yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hal Fleck M.D.

Oct 24 (Address) North Ave & Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lusby Cem	Oct 28 1923

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 80239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D 80239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Harford Av ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Brown.

(a) RESIDENCE NO. 1227 Harford Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 04 24 1923

7 AGE: Years | Months | Days | If LESS than 1 day, 6 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NO

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Harold R. Brown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lula E. Buckman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Harold R. Brown

(Address) 1227 Harford Av

15 Filed OCT 25 1923, 19 ROBERT R. KNABE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1923, to Oct 24, 1923, that I last saw h in alive on Oct 24, 1923, and that death occurred, on the date stated above, at 7-15 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Foramen Ovale not closed

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. L. Fair, M. D.

Oct 24, 1923 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Oct 25 1923

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Allen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 80240

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 N. North Ave ST., 14 WARD)

2-FULL NAME Wilbur F Manahan

(a) RESIDENCE NO. 741 N North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 006
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Jabez Manahan
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio
12 MAIDEN NAME OF MOTHER Sarah A Reese
13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Ida M. Klemm
(Address) 1902 Eutaw ave

15 Filed OCT 25 1923 19 ROBERT R. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jul, 1922, to Oct 23, 1923, that I last saw h-- alive on Oct 23, 1923, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mel

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis. Angina Pectoris (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Urtan Smith M. D.

19 (Address) 817 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loyola Mount Cemetery | DATE OF BURIAL Oct 1923

20 UNDERTAKER John O. Mitchell | ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Wang Wing

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80241 — 90 — B 80241

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Park Ave ST., 4 WARD)

2-FULL NAME Wang Wing

(a) RESIDENCE No. 230 Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Chinese	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant 045
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) China
(State or country)

PARENTS

10 NAME OF FATHER Wong Da Jog

11 BIRTHPLACE OF FATHER (city or town) China
(State or country)

12 MAIDEN NAME OF MOTHER Chin Shee

13 BIRTHPLACE OF MOTHER (city or town) China
(State or country)

14 Informant Mrs Hong
(Address) 230 Park Ave md

15 Filed ..... 192 ..... Registrar

OCT 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) H K Grumbine, M. D. (Coroner.)

10/25, 192... (Address) 111 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 29 1923
20 UNDERTAKER	ADDRESS
John D. Mitchell	1201 W Fayette

NOTICE PLEASE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80242

CERTIFICATE OF DEATH.

3/ D 80242

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 S. 1st ST., 25 WARD)

2-FULL NAME Anton Holewczynski

(a) RESIDENCE No. 823 S 1 St ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1883 Sept 26

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) — 006

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Silvester Holewczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Johanna Holewczynska

(Address) 823 S 1st St

Filed OCT 25 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from October 23, 1923, to October 24 1923, that I last saw h[illegible] alive on October 24, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ... yrs. mos 12hrs

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromshas, M. D.

10-24 1923 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem — DATE OF BURIAL Oct 27 1923

20 UNDERTAKER Stephen J. Kalkowski — ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

1618 W. Mulberry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80243

CERTIFICATE OF DEATH.

31 Aug 22. 1920

D 80243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 N Ellamont ST., 20 WARD)

2-FULL NAME Alease Watters

(a) RESIDENCE NO. 321 N Ellamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug 22 1920

7 AGE — Years: 3 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Victor Watters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louella Dorsey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Louella Watters

(Address): 321 Ellamont

15 Filed , 19 ROBERT R. KRAUTER, Registrar

OCT 26 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-24 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-20-23, 19 23, to 10-24, 19 23, that I last saw h[illegible] alive on 10-23, 19 24, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (over)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlawn Hill — DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Jos. T. Foster — ADDRESS: Beltsville, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING: RESEMBLES FORM BEARING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tubercular attack.

Consumption after pneumonia

Cor.—1-12-23—M&T—100 Bks.

D 80244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 113

D 80244

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 E. Madison ST., 10 WARD)

2-FULL NAME Dorothy Hellum

(a) RESIDENCE NO 922 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX XX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lynchburg Va.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Hellum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Gertrude White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Gertrude White
(Address) 922 E. Madison St.

15 Filed OCT 25 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition-Diarrhoea

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dentition-Poor feeding.

(duration) yrs. mos. ds.

(Signed) J. S. Powers, M. D.
(Coroner.)

10/24/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 10/25 1923

20 UNDERTAKER James N. Powers

ADDRESS 1313 Fe Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80245

CERTIFICATE OF DEATH.

90 ✓ D 80245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, ST., 16 WARD)

2-FULL NAME Nathanial Gardiner

(a) RESIDENCE NO. 1919 Hillock St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1923

17

I HEREBY CERTIFY, That I attended deceased from October 20, 1923 to October 21, 1923, that I last saw him alive on October 21, 1923, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis (Degen.)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure (Acute)

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Thomas, M. D.

10-22 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 10/25 1923

20 UNDERTAKER Jos. N. Davis

ADDRESS 1303 Pennsylvania

OCT 25 1923 ROBERT P. KRAUTER Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80246 160 ✓ D 80246

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) (ST., 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Powers

(a) RESIDENCE NO. 419 E 25th ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year): Oct 18, 1923
7 AGE: Years | Months | Days: 2 | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md. Maryland

PARENTS
10 NAME OF FATHER: Joseph F. Powers
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland
12 MAIDEN NAME OF MOTHER: Helena Martin
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belair Maryland.

14 Informant: Parents (Address) 419 E 25th St.

15 Filed OCT 25 1923 Registrar ROBERT R. KRAUTER Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-21-23

17 I HEREBY CERTIFY, That I attended deceased from 10-18-23, 19 . to 10-21-23 19 .
that I last saw h[illegible] alive on 10-21-23 19 ,
and that death occurred, on the date stated above, at 6 30 a m.
The CAUSE OF DEATH* was as follows:
Prostatic Catheterization
3# infant, full term.

(duration) yrs 9 mos ds.
CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) Geo A Dempsine M. D.
. 19 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: Oct 25 1923

20 UNDERTAKER: E. A. Wiedefeld Jr. — ADDRESS: 501 E 22

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80247

CERTIFICATE OF DEATH.

129 D 80247

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 E. 23 St.; 9 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Mullen

(Residence in Baltimore: No. 514 E. 23 St.; 50 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, March 17, 1845 (Month) (Day) (Year)

7-AGE, 78 yrs. 8 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Mullen

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Carney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary R. Fahey

(Address) 818 W Preston Ave

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1923, to Oct 24 1923, that I saw him alive on Oct 22 1923, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis Interstitial Sclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) C. Stanley Gorsuch M. D.

10-24, 1923 (Address) 1900 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 26, 1923

20-UNDERTAKER E. A. Wedefeld & Son — ADDRESS 501 E. 22 St.

ROBERT R. KRAUTH
OCT 25 1923
SOCIAL PEACE

Spec.—1-10-21—M&T—1500 Bks.

(Stenson) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80248

D 80248

CERTIFICATE OF DEATH.

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1149 Mount ST. 16 WARD)

2-FULL NAME Mary B. Stenson

(a) RESIDENCE NO. 1149 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Stenson

6 DATE OF BIRTH (month, day, and year) [illegible] 1887

7 AGE Years 36 Months Days

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md, Balto.

PARENTS

10 NAME OF FATHER David Burk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Va

12 MAIDEN NAME OF MOTHER Sarah Parran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ~~D~~ Maggie D. Commodore

(Address) 1526 Mount St

15 Filed OCT 25 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/6 1923, to 10/22 1923,

that I last saw h[illegible] alive on 10/22 1923,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 30th 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkett, M. D.

10/24 1923 (Address) 2139 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and t2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 25 1923

20 UNDERTAKER John H. Toadvine

ADDRESS 142 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 80249 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80249

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Van Lill

(a) RESIDENCE NO. 1017 W. Cross St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 5 1922

7 AGE — Years: 1 — Months: 7 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ed. Van Lill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Kate Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ed. Van Lill (Father)

(Address) 1017 W Cross St

15 Filed, . 19 . Registrar

OCT 23 1923 ROBERT R. KRAUTER CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1923, to Oct 25, 1923, that I last saw her alive on Oct 25, 1923, and that death occurred, on the date stated above, at 1:20 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria nasal pharyngeal & laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures.

(Signed) Bella Lawson M. D.

19 23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 25 1923

20 UNDERTAKER: Harry J. Wilkie — ADDRESS: 1031 N Londond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 80250

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 China St.; W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Wilson

(a) RESIDENCE. No. 817 China St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? 31 yrs. mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug 28/1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kent island Md

PARENTS

10 NAME OF FATHER: Wm. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent island Md

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent island Md

14 Informant: Hattie Brown

(Address): 817 China st

15 Filed . 19 .

Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 21, 1923, that I last saw h[illegible] alive on Oct 21, 1923 and that death occurred, on the date stated above, at 10.50 P.M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

about (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Sputum examination

(Signed) O. H. Carroll M. D.

(Address) 140 Mountill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cemetery	Oct 25 1923

20 UNDERTAKER	ADDRESS
Jno Geo H Hooper	406 W. Conway st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 80251

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Donnelly Court ST., 10 WARD)

2-FULL NAME David Dorsey

(a) RESIDENCE NO 908 Donnelly Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Dorsey

6 DATE OF BIRTH (month, day, and year) Nov 6/1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Builder
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David Dorsey Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Susan Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Rosa Dorsey
(Address) 908 Donnelly Court

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22/192 23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Haller, M. D. (Coroner.)

10/25/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL Oct 26 1923

20 UNDERTAKER Geo. R. R. Elliott — ADDRESS 1772 Mulberry

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80252

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 80252

CERTIFICATE OF DEATH.

X 52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 438 E. North Ave (ST.) 12 (WARD)

2-FULL NAME Bridget Coffey

(a) RESIDENCE. No. 438 E. North Ave ST., WARD. 17

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 46 ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Jos Coffey

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes J. Keating (Address) 438 E. North Ave,

15 Filed , 19 Registrar

OCT 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1923, to Oct 24, 1923

that I last saw her alive on Oct 24, 1923

and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis - old age

Chronic Rheumatism

(duration) 5 yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark, N. J.	Oct 26th 1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son - 9316	Lafayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80253

CERTIFICATE OF DEATH.

179 D 80253

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Mercy Hospital ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Curran

(Residence in Baltimore: No. 216 N. Ellwood Ave St. Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE. 57 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boiler Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Continental Tidet Co

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Johnson

(Address) 216 N. Ellwood Ave

15-

Filed ..... 191.....

OCT 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 2nd degree

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septicemia Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Kelly M. D.
(Coroner.)

Oct 24, 1923 (Address) 1823 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem. DATE OF BURIAL, 10/26, 1923

20-UNDERTAKER Chas F. Wood & Son ADDRESS 1180 N Royal ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80254

CERTIFICATE OF DEATH.

129 D 80254

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1521 Leslie ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Rayne

(a) RESIDENCE NO. 1521 Leslie ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or min.
30	—	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Albert Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Sophia Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rebecca Cousins (Address) 152 Leslie St

15 Filed OCT 25 1923 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Oct 22 1923, that I last saw h[illegible] alive on Oct 21, 1923 and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (duration) yrs. not known mos ds.

CONTRIBUTORY (Secondary) Dilatation of Heart (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

10/25 1923 (Address) 1521 Freshman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10/26 1923

20 UNDERTAKER Saml Wrenley

ADDRESS 1[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80255 ✓ 46 D 80255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Ratchet

(a) Residence No. 698 Eiselen St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1888

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS

10-NAME OF FATHER: Richard Wilkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Hannah Flowers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14- (Informant): Municipal Hospital Records

(Address):

15- Filed OCT 25 1923 192 . ROBERT R. KRAUER Registrar.

Burial Permit Issued OCT 25 1923

0814

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1923, to October 23 1923, that I last saw her alive on October 23 1923, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix -

(Duration) yrs. 6 (?) mos. ds.

CONTRIBUTORY (Secondary) Metastasis to spine -

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10-24, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
JOHNS HOPKINS HOSPITAL	
20-UNDERTAKER. Commissioner Health.	ADDRESS OCT 25 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

322

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80256

CERTIFICATE OF DEATH.

22-002

D 80256

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5104 York Road ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen C. Morris

(a) RESIDENCE NO. 5104 York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 7-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	81	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Local Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co Md

PARENTS

10 NAME OF FATHER Henry D Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah C Collinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Mrs L A Rowell 5704 York Road

15 Filed OCT 25 1923 19 ROBERT R. KRAUTER, Registrar

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1923, to Oct 24, 1923, that I last saw him alive on Oct 23, 1923, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Ravages of old age

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Enlarged Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Oct 24, 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooked Hill Forest	Oct 26 1923

20 UNDERTAKER D S Marshall ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1711 Hilton

City of BALTIMORE: (No. ..... St., 15 Ward) Registered No. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Shingler

(a) Residence No. 1711 Hilton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 20, 1844

7-AGE. 73 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) John J. Shingler

(Address) 1711 Hilton St

15-

Filed ..... 192.....

ROBERT R. KRAUTER

Registrar.

OCT 25 1923

Board of Health Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 24 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1923 to Oct 24 1923

that I last saw h. living on Oct 24 1923

and that death occurred, on the date stated above, at 3.20 A m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Foot infection

(Duration) 0 yrs. 0 mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) S A Dodds M. D

Oct 25 1923 Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Leitrim Catonsville Md

DATE OF BURIAL. Oct 28 1923

20-UNDERTAKER Jno J Smith

ADDRESS 1532 Hollins St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80258 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80258
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2901 Brighton St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Ryan

(a) Residence No. 2901 Brighton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) april 11. 1872

7-AGE, 51 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS

10-NAME OF FATHER, Anthony Davenport

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Frances Masterman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md.

14- (Informant) Mr P. J. Ryan

(Address) 2901 Brighton St

15- Filed OCT 25 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 23 1923

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1921 to Oct. 23, 1923.

That I last saw h alive on Oct. 23, 1923

and that death occurred, on the date stated above, at 10.20 am

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 2 yrs. 2 mos. 8 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy M. D.

Oct. 24 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Oct. 26 1923

20-UNDERTAKER Margaret A. Flynn — ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80259

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Mrs. Helen Cooksey

(a) RESIDENCE No. 3525 Newland St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) ~~WIFE of~~ Manuel Cooksey

6 DATE OF BIRTH (month, day, and year) May 27 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	38	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER E. A. Waddington

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER Mary Heesloe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant Ernest A. Waddington

(Address) 3525 Newland St Guilford

15 Filed OCT 25 1923 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Oct 24, 1923, that I last saw her alive on Oct. 24, 1923, and that death occurred, on the date stated above, at 8-35 A.m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of the liver

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 22-1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) P.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lauriston Cem. DATE OF BURIAL: Oct 26 1923

20 UNDERTAKER: Chas. E. Speed ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Removal of gall Bladder

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80260 D 80260

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemon Solomon

(a) RESIDENCE NO. 804 N. Calvert ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	75	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

166

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Joseph Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rose Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Relative

(Address) Johns Hopkins Hosp.

15 Filed OCT 25 1923, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1923, to Oct 24, 1923, that I last saw him alive on Oct 24, 1923 and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pneumonia, Lobar

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shale, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City — DATE OF BURIAL 10/25/1923

20 UNDERTAKER David Sondheim — ADDRESS 118 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

MARR

D 80261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80261

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 361 N Maple Ave ST., (13) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Helen E. Marr

(a) RESIDENCE NO. 361 N Maple Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 13-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk, Med Laundry.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country): Oakland Mills Howard Co Md.

PARENTS

10 NAME OF FATHER: John W. Marr Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Md.

12 MAIDEN NAME OF MOTHER: Lilly Dickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): King George Va

14 Informant: John W. Marr Jr.

(Address): 361 N Maple Ave.

15 Filed OCT 25 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Oct 23, 1923,

that I last saw her alive on Oct 23, 1923,

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mo 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe Thom, M. D.

Oct 24, 1923 (Address) 243 N Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Oct. 26 1923
20 UNDERTAKER	**ADDRESS**
Horace H. Burgee	363 Fallsld.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 80262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80262

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2548 Eager Place ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Messner

(a) RESIDENCE NO. 2548 Eager Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXXXXXX

6 DATE OF BIRTH (month, day, and year): Dec 23/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 50 0
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. Messner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Barbara Holthaus
(Address): 2548 Eager Place

15 Filed ..... 192 ..... Registrar

10/25/1923 Robert F. [illegible] Deputy Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Osteomyelitis (left hip) (duration) since childhood mos. ds.

(Signed) J. Scott Paul, M. D.
(Coroner.)

10/25/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 26/23

20 UNDERTAKER: Wm Cook — ADDRESS: E. North Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—3500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 80263

REGISTERED NO. D. 80263

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hubbard Burke

(a) RESIDENCE NO. Fantroy at, Va. R.F.D. ST., WARD Fort Royal Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Thomas Burke~~

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lula Ridgway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Record John Hopkins Hosp

15 Filed , 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Oct 24, 1923, that I last saw h alive on Oct 24, 1923 and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis - due to Tonsilar histolytic

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W Va

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Cultures

(Signed) Warfield M Firor, M. D.

10/25, 1923 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Royal Va. DATE OF BURIAL Oct 26 1923,

20 UNDERTAKER William G. Schaffer ADDRESS 816 E. Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 80264 — 100-001 — D. 80264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (St.) 3 (WARD)

2-FULL NAME Antonio ~~Guardino~~ Gurino

(a) RESIDENCE No. 207 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9th 1922

7 AGE — Years: 1 — Months: 1 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Gurino

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Victoria Capilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Joseph Gurino 207 S. Exeter St

15 Filed , 19 ... Registrar

OCT 25 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1923, to Oct 24, 1923, that I last saw h[illegible] alive on Oct 24, 1923, and that death occurred, on the date stated above, at 1150 m.

The CAUSE OF DEATH* was as follows:

Pleural Effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thornwood Wilson, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 26th 1923

20 UNDERTAKER: Martin W. E. Dippel — ADDRESS: 37 S. Conn St

MARRIAGE RESERVED FOR BIRTHS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—10[illegible]ks.

(Mathews)

D. 80265

D. 80265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1276 Mount ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Mathews

(a) RESIDENCE NO. 1276 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	37	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Johns Peals

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Texas E. Matthews
(Address) 1276 Mount St

15 Filed ..., 192.. Robert P. Harrison, Registrar
CT 251923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Dil Heart, 2d

(Duration) Infect Throat yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (Duration) mos. ds.

(Signed) J. C. Clades, M. D.

Oct 23, 1923 (Address) 1236 Eng

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 29 1923

20 UNDERTAKER Brown & Fieland

ADDRESS 1140 Druid Hill Ave

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D. 80266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 80266

74-001 [redacted]

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1602 Shakespeare ST., 7 WARD)

2-FULL NAME Tomas Zdak

(a) RESIDENCE No. 1602 Shakespeare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Name Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 47	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Tekla Brzyska
(Address) 1602 Shakespeare St

15 Filed OCT 25 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to h.. death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) about one day yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 25, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct. 26 1923
20 UNDERTAKER	ADDRESS
John McWeeney	1803 Bank St

Robert R. Harrison, Register

OCT 25 1923

Form 1-12-23—M&T—100 Bks.

WHITE PAPER, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D.80267 HEALTH DEPARTMENT—CITY OF BALTIMORE D.80267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 731

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Duback

(a) Residence No. 507 W. Washington st. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

8-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6-DATE OF BIRTH (month, day and year): 1884

7-AGE: 39 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Jake Duback

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Agnes Peters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed ..... 192 ..... Registrar.

OCT 25 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 1923 to Oct. 24 1923

that I last saw him alive on Oct. 24 1923

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia (Duration) Unknown yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum and X-ray

(Signed) L. A. Lally M. D

10-24-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. St. Stanislaus — DATE OF BURIAL: Oct. 27, 1923

20-UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank

...—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D. 80268 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 80268

CERTIFICATE OF DEATH.

31

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 333 S Ann ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. Obrycki

(a) RESIDENCE No. 333 S Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Obrycki

6 DATE OF BIRTH (month, day, and year) May 23 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Obrycki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs Dorothy Obrycki 333 S Ann

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Gd Luy Fros

(duration) yrs. mos. 1 ds.

(Signed) Geo E. Blades, M. D.

(Coroner.)

Oct 24 1923 (Address) 1436 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct. 27 1923

20 UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 80269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80269

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S Wolfe ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Pawlowski

(a) RESIDENCE. NO. 414 S Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Pawlowski

6 DATE OF BIRTH (month, day, and year) Sept 25 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	64	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

640

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caroline Wiesniewska

(Address) 320 S Ann St

15 Filed OCT 25 1923, 19 Robert F. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 23, to October 23, 19 23, that I last saw h Mrs alive on Oct 23, 19 23, and that death occurred, on the date stated above, at 9.30 a m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) B K Herzog M.D. M. D.

Oct 23 1923 (Address) 1305 n Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Oct 27 1923

20 UNDERTAKER — ADDRESS

John A Weber — 1803 Bank

17

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 80270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-22 D. 80270

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Cole ST., 19 WARD)

2-FULL NAME Rosa Kretz

(a) RESIDENCE NO. 1716 Cole ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph Kretz

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	I	I9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Francis A. Mitchell

(Address) 1716 Cole St.

15 Filed DEC 25 1923, 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1923, to Oct 23, 1923, that I last saw h[illegible] alive on Oct 22, 1923, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis.

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) M. Greisinger M. D.

19 (Address) 68 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 25 19 23.

20 UNDERTAKER Harry H. Weitzel

ADDRESS 1531 W. Lombard St

MARGIN RESERVED FOR BINDING

6.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(William Scharon)

D. 80271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 80271

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Scharon

(a) RESIDENCE NO. 1419 N Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer [redacted] RR

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Scharon

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Shipley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary Scharon
(Address) 1419 N Bentalou St

15 Filed , 192 Registrar

C 1 25 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [redacted]y or inquiry.) thereon and from the evidence obtained by said [redacted] find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock resulting from fractured leg & injuries to body, being struck by auto (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by auto (duration) yrs. mos. ds.

(Signed) W. H. Jarrett, M. D.
(Coroner.)

10-25, 1923 (Address) 11 N Santa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge | DATE OF BURIAL Oct 27 1923

20 UNDERTAKER Wm Cook | ADDRESS 502 E North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80272

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3527 Gwynn Oak Ave WARD 24)

2-FULL NAME Mr. Timothy James Driscoll

(a) RESIDENCE NO. 3527 Gwynnbrook Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Peggy Driscoll

6 DATE OF BIRTH (month, day, and year) Feb 22-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63 yrs.	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone cutter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Richmond - Va.

PARENTS

10 NAME OF FATHER James Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Dwyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs L. Driscoll.
(Address) Cockeysville Md

15 Filed OCT 25 1923 19.... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29. 1923. to Oct. 24. 1923. that I last saw him alive on Oct 23. 1923. and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? X ray

(Signed) Hunter C. Wood M. D.

10/25 1923 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral DATE OF BURIAL: Oct 27, 1923

20 UNDERTAKER: Wm Cook & Son ADDRESS: Ft Worth Tex

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80273, D 80273.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80273 CERTIFICATE OF DEATH. 74-001 D 80273

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1726 (ST.) Harford Ave (WARD) 9

2-FULL NAME Bridget McEnroe

(a) RESIDENCE NO. 1726 (Usual place of abode) Harford Ave ST., WARD

(If not a resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick McEnroe

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: abt. 65 Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: M. Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs. Mary McKevitt. 1726 Harford Ave

15 Filed OCT 26 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 25. 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1923 to Oct 25 1923

that I last saw her alive on Oct 24 1923

and that death occurred, on the date stated above, at 5.10 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy, Cerebral Hemorrhage

Duration: Bronic Nephritis 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis N. A. Mayer M. D.

10/25, 1923 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 29 1923

20 UNDERTAKER: Henry Storch, Son — ADDRESS: 1201 E Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12-23-21—E.B.R.S.—400 Bks.

D 80274 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80274

D 80274 CERTIFICATE OF DEATH. 89 D 80274

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 2204 N. Calvert St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Merrick

(a) Residence No. 2204 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: M. Barton Merrick

6-DATE OF BIRTH (month, day and year): July 7th 1867

7-AGE: 56 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Talbot Co Md

PARENTS:
10-NAME OF FATHER: Wm Castorfield
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Talbot Co Md
12-MAIDEN NAME OF MOTHER: Caroline Lloyd
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Talbot Co Md

14-
(Informant): M. Barton Merrick
(Address): 2204 N. Calvert St

15-
Filed OCT 26 1923, 192
ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 24th 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1922 to Oct 24 1923
that I last saw her alive on Oct 23 1923
and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:
Angina Pectaris
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterial Sclerosis
(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? High Blood Pressure & myocarditis.
(Signed) J. H. Chilliss M. D
Oct 25 1923 (Address) 23 E Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: 10/26/23

20-UNDERTAKER: Geo. Weber & Son ADDRESS: 2503 Edmondson ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 80275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80275

CERTIFICATE OF DEATH.

129

D 80275

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Hanover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Wissner

(a) RESIDENCE. No. 810 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Wissner

6 DATE OF BIRTH (month, day, and year) Nov 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dumstadt Germany

PARENTS

10 NAME OF FATHER Do not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Louis Wissner 810 Hanover St

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

OCT 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13 1923 to Oct 24 1923

that I last saw him alive on Oct 22nd 1923

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Several Years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick M. D.

19 (Address) 412 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Druid Hill Park	Oct 26 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Autopsy & Inquest Gaspare Giordano

D 80276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80276

CERTIFICATE OF DEATH.

197 D 80276

D 80276

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 5 WARD)

2-FULL NAME Gaspare Giordano

(a) RESIDENCE NO. 271 East Lan ST., ... WARD .....

(Usual place of abode) 271 N. Exeter St (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 15 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francesca Lito

6 DATE OF BIRTH (month, day, and year) March 26 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Italy

PARENTS

10 NAME OF FATHER Vincenzo Giordano

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Anita Cinda

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Italy

14 Informant Francesco Lito
(Address) 271 N Exeter St

15 Filed OCT 26 1923, 192.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wounds of thorax

a few hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D. (Coroner.)

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 10/26 1923

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

NOTE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Myrtle Ave ST., 14 WARD)

2-FULL NAME Amanda Oliver

(a) RESIDENCE No. 1407 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolphus Oliver

6 DATE OF BIRTH (month, day, and year) about 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	70 Yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henson Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Oscar Waters (Address) 1407 Myrtle Ave.

15 Filed OCT 26 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Oct. 24 1923 (Address) 2702 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL 10/26 1923

20 UNDERTAKER Samuel Hawsley | ADDRESS 1700 E. Baltimore St.

IMPORTANT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80278 — CERTIFICATE OF DEATH. — X 101-09 D 80278

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Eiselen ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Habersham

(a) RESIDENCE NO. 614 Eiselen ST., WARD Georgia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May - 1 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	7	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Savannah
(State or country) Georgia

PARENTS

10 NAME OF FATHER James Habersham

11 BIRTHPLACE OF FATHER (city or town) Ridgeland
(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Mamie Walker

13 BIRTHPLACE OF MOTHER (city or town) Savannah
(State or country) Georgia

14 Informant James Habersham
(Address) 614 Eiselen St.

15 Filed OCT 26 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 21, 1923, to Oct, 25, 1923, that I last saw him alive on Oct, 24, 1923, and that death occurred, on the date stated above, at 4 a, m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) 1 yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dan Franklin, M. D.

10/25 1923 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	Oct 27 1923
20 UNDERTAKER	ADDRESS
A. Lee Brown & Son	108 N. Mart

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80279

CERTIFICATE OF DEATH.

89 D 80279

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Fernwood Ave ST., 16 WARD)

2-FULL NAME Ella Jane Lewis

(a) RESIDENCE No. 1022 S. Bouldin ST., ...WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Azrail Lewis

6 DATE OF BIRTH (month, day, and year): July 20th 1856

7 AGE — Years: 67 — Months: 3 — Days: 5 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Milton Pa.

PARENTS

10 NAME OF FATHER: Abraham Leib

11 BIRTHPLACE OF FATHER (city or town) (State or country): Milton Pa.

12 MAIDEN NAME OF MOTHER: Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Milton Pa.

14 Informant: Mrs Robert Stumpf
(Address): 3603 Fernwood Ave.

15 Filed OCT 26 1923, 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 25, 1923

that I last saw her alive on Oct 24 1923

and that death occurred, on the date stated above, at 11.25 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ....yrs. ....mns. ....ds.

18 Where was disease contracted if not at place of death?....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Sutton M. D.

10/26, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem.

DATE OF BURIAL: Oct 28th 1923

20 UNDERTAKER: Philip Herwig

ADDRESS: 2016 Orleans St

MARGIN RESERVED FOR BINDING

RITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80280

129 D 80280

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belvedere Hotel ST. 14 WARD)

2-FULL NAME Kate Abrahams Stran

(a) RESIDENCE No. 1912 Eutaw Place ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced, (write the word)~~
Female	White	Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND of~~ (or) WIFE of Thos Parramore Stran

6 DATE OF BIRTH (month, day, and year) 1845-2-11

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Woodward Abrahams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret E. Pillig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Summer A Parker. (Address) 1112 Linden ave

15 Filed OCT 26 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Oct 25, 1923, that I last saw h. alive on Oct 24, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia (Chronic Nephritis)

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Myocarditis

Symptoms (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Hamburger M. D.

Oct 26, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 10-27 1923

20 UNDERTAKER Henry W Perkins & Hoor Co ADDRESS 847 Cullob & Orchard

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 80281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 80281

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Madeira ST.; 7 WARD)

2-FULL NAME John Risinger

(a) RESIDENCE. No. 825 N. Madeira ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos ds.

IMPORTANT—RESERVED FOR BIRTHS

PLEASE PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Anna Risinger

6 DATE OF BIRTH (month, day, and year): Oct 7 1834

7 AGE: 89 Years 89 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Risinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mary Kapischka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Marie Base

(Address) 825 N. Madeira

15 Filed OCT 26 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923 to Oct 24, 1923

that I last saw him alive on Oct 24, 1923

and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Kuchler D

Oct 24, 1923 (Address) 600 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 27 1923

20 UNDERTAKER: Smith Crook & Son — ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 80282 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 7 ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Thomas

(a) RESIDENCE NO. Blacksburg St. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1822

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER — Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Oct 20, 1923, that I last saw h[illegible]live on Oct 20, 1923 and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac failure

Exp

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exploratory laparotomy after post operative

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/16/23

Was there an autopsy? Yes REMOVAL OF TONSILS

What test confirmed diagnosis?

(Signed) R. R. Hannon, M. D.

10/26, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blacksburg Va. DATE OF BURIAL 10/26/23

20 UNDERTAKER H. E. Hughes ADDRESS 1st & Broadway

MARGIN RESERVED FOR BINDING

E PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT R. KRAUTER
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

D 80283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80283

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Washington Bulv. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Karpavicene

(a) RESIDENCE NO. 617 Washington Bulv. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1849

7 AGE 74 Years – Months – Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Joseph Sakocus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Noknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Jule Zalneritene

(Address) 617 Washington Bulv.

Filed Oct 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25. 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct-23. 1923. to Oct-25 1923.

that I last saw h alive on Oct-25 1923

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No "Clinical

What test confirmed diagnosis?

(Signed) M.D. M. D.

10/25/23 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOLY REDEEMER	Oct. 29. 1923
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	425 S Paca St

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 8 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Thompson

(a) RESIDENCE NO. 1922 Hennenman Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records.
(Address)

Filed ..... 19 .....
Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 6, 19 23, to October 25, 19 23, that I last saw h[illegible] alive on October 21, 19 23, and that death occurred, on the date stated above, at 1:10 A. M.

The CAUSE OF DEATH* was as follows:

Caranoma of Rectum

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Horace, M. D.

10-25-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 27 19 23

20 UNDERTAKER: [illegible] Cook — ADDRESS: 502 E Fayette

MARGIN RESERVED FOR BINDING

ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80285

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 D 80285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 Ridgely St.; WARD 21)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia A. Parker

(a) RESIDENCE. No. 1148 Ridgely St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Robert Parker

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Wm. H. Parker 1133 Ridgely St.

15 Filed , 19 Registrar

T261923

Robert P. Harrison
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Oct 26, 1923, that I last saw her alive on Oct 25, 1923, and that death occurred, on the date stated above, at 4.01 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Oct 26, 1923 (Address) 1404 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Christ — DATE OF BURIAL: Oct 29, 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 East Baltimore

SEVERAL ITEMS WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167796 D 80286 — D 80286 — X 118-00 — D 80286

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Foster

(a) RESIDENCE NO. 406 E. Green St. ST., WARD Wilson, N. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 week mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Dec~~ ?

6 DATE OF BIRTH (month, day, and year) Sept 4 - 1883

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

069

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER John Deme

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Jaynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address)

15 Filed , 19 Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923, to Oct 25, 1923, that I last saw h e alive on Oct 25 1923 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Prophequtic Hernia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital

Did an operation precede death? Yes Date of Oct 19, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem Section

(Signed) E. E. Duncan, M. D.

10/26, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson, N. Carolina — DATE OF BURIAL Oct 26 1923

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

KEEP WRITING SHOULD BE PRESSED FOR BINDING

...WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80287

CERTIFICATE OF DEATH.

89

D 80287

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3435 E. Baltimore St. ST.: 76 WARD)

2-FULL NAME Elizabeth M. Friedel

(a) RESIDENCE. No. 3435 E. Baltimore St. ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Friedel

6 DATE OF BIRTH (month, day, and year) April 29-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER John H. Bunger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Sophie Lapziehn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) Agnes C. Butler 3519 E. Balto St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 25, 1923, that I last saw her alive on Oct 25, 1923, and that death occurred, on the date stated above, at 4.10 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation.

(Signed) Horace S. Fillow, M. D.

10/26, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 29 1923.
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	4038 Wolfe St.

NDING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD ... supplied. AGE should be stated EXACTLY. PHYSICIANS ... information should be carefully supplied. ... that it may be properly classified. Exact statement of OCCUPATION ... SE OF DEATH in plain terms, so that it ... important. See instructions on back of certificate.

D 80288

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-007 D 80288

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 3231 Colgate St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rosie Jelenowski

(Residence in Baltimore: No. 3231 Colgate St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1854 (Year)

7 AGE: 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): Poland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (State or country): Poland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Poland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Jelenaski (Son)

(Address) 3231 Colgate St.

15 ..... 191 .....

Robert P. Harrison,
Burial Permit Clerk.
REGISTRAR

261923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 24 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Oct 24 1923

that I saw her alive on Oct 24, 1923

and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Senile Bronchitis

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) W. L. Burke M.D.

Oct 26, 1923 (Address) 3040 Hudson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Oct. 27, 1923

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

D 80289 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80289

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Fremont Ave. WARD) 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. White

(a) RESIDENCE NO. 231 N Fremont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 4 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	37	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Jewel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER James H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) King W. Va

12 MAIDEN NAME OF MOTHER Anna R. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) George Co Md

14 Informant Susie Carter

(Address) 231 N Fremont

15 Filed OCT 26 1923, 19 Registrar

Robert P. Harrison, Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1923 to Oct 24, 1923

that I last saw him alive on Oct 23, 1923

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Howells M. D.

19 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10-28 1923
20 UNDERTAKER Dan Harford	ADDRESS 916 Mt Auburn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 80290 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80290

CERTIFICATE OF DEATH. 100-001

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 15 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lewis

(a) RESIDENCE NO. 1619 Presbury St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... , 19 ..... Registrar

OCT 26 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to October 24, 1923, that I last saw her alive on October 23, 1923, and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Obesity

Arteriosclerosis + Hypertension

Cardio-Renal Disease

(duration) 1 yrs. (History) mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude A Kreas, M. D.

10-25, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-25 19 23

20 UNDERTAKER Dan'l Lowber

ADDRESS Penna Ave

(Tempie Maitland)

Spec.—8-24-14—M. & T.—2000 Bks.

D 80291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80291

CERTIFICATE OF DEATH.

101-00

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 774 Dover St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tempie Maitland

(Residence in Baltimore: No. 774 Dover Street St.; 40 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. 8 (Month) 1865 (Day), 1 (Year)

7-AGE, 58 yrs. 1 mos. 18 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): H

9-BIRTHPLACE, (State or Country), N. C

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Maitland

(Address) 774 Dover St

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

OCT 26 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1923 to Oct 25 1923, that I saw h[illegible]alive on Oct 25 1923, and that death occurred, on the date stated above, 11.45 m.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) 8 yrs. ..... mos. 6 da.

CONTRIBUTORY (Secondary) [illegible]

(Duration) ..... yrs. ..... mos. 6 da.

(Signed) [illegible] M. D.

Oct 26 1923 (Address) 714 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Oct 26, 1923

20-UNDERTAKER Jno Gelt Hodges

ADDRESS 406 W. Camden St

N.B.—Every item of information should be carefully supplied. Ages, dates and birthplaces must be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80292

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519 Forrest St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Jenkins

(a) RESIDENCE. NO. 3519 Forrest ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Wm J Jenkins

6 DATE OF BIRTH (month, day, and year) June 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Mildred Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm J Jenkins
(Address) 3519 Forrest St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 11 . 19 23 . to Oct 6 11 . 19 23

that I last saw h.. alive on Oct 6 11 . 19 23 .

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic heart disease (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? (No) Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) T. J. Gilliam . M. D.

10/26 19 23 (Address) 1107 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Oct 29 23
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C... TION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80293

CERTIFICATE OF DEATH.

31 D. 80293

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 789 George ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Meredith-

(a) RESIDENCE NO. 789 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) -1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm Hales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robinson Meredith- (Address) 789 George St

15 Filed OCT 27 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16th, 19 23 to Oct. 24th, 1923, that I last saw her alive on Oct. 24th, 19 23, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul. tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Ellis, M. D.

Oct 25, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Oct 26 23

20 UNDERTAKER Dan'l Wm Ley ADDRESS Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Robert P. Harrison, Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80294 D 80294

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Mc Culloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Newman

(Residence in Baltimore: No. 1610 Mc Culloh St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 20 (Day), 1883 (Year)

7-AGE, 18 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0 Y 0

9-BIRTHPLACE, (State or Country), Col.

PARENTS.

10-NAME OF FATHER, Wash. M. Newman

11-BIRTHPLACE OF FATHER (State or Country), Col

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Newman

(Address) 1610 Mc Culloh St

15-

Filed ..., 191.. Robert P. Harrison Registrar.

OCT 27 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 10 1923, to Oct 24 1923, that I saw h in alive on Oct 24 1923, and that death occurred, on the date stated above, at 5:40 p m.

The CAUSE OF DEATH* was as follows: (a) Pulmonal Tuberculosis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 4 mos. ds.

(Signed) W. T. Coleman M. D.

Oct 25, 1923 (Address) 703 E. Mc Culloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Lubyn Cem DATE OF BURIAL Oct 27 1923

20-UNDERTAKER Chas. J. Hamsley ADDRESS Reddish

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80295 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D 80295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 908 Lanvale Ave St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosetta Forrester

(a) Residence No. 908 Lanvale Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Apr. 11 23

7-AGE, — yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work — Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto, (State or Country),

PARENTS.

10-NAME OF FATHER, Hedk Foster

11-BIRTHPLACE OF FATHER (city or town) Balto, (State or Country),

12-MAIDEN NAME OF MOTHER, Estelle Morgan

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country),

14- (Informant) Isabella Forrester

(Address) 908 Lanvale st

15- Filed OCT 27 1923 19.. Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25-23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11, 19 23, to Oct. 25, 19 23

that I last saw her alive on Oct. 25, 19 23

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(over)

(Duration) yrs. mos. ds.

CONTRIBUTORY — (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Frank E. Wright M. D.

10/26 1923 (Address) 926 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem — DATE OF BURIAL, Oct 27th 19 23

20-UNDERTAKER, A. Jones — ADDRESS, 111 S. Gilmor st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D 80296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80296

CERTIFICATE OF DEATH.

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 W. West ST. 21 WARD)

2-FULL NAME Henrietta V. Dorman

(a) RESIDENCE No. 520 W. West ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of: Daniel Dorman

6 DATE OF BIRTH (month, day, and year): Apr- 17-1884

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
39	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Clover
(State or country) Virginia

PARENTS

10 NAME OF FATHER Edward Sydnor

11 BIRTHPLACE OF FATHER (city or town) Clover
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Susie Bauns

13 BIRTHPLACE OF MOTHER (city or town) Clover
(State or country) Virginia

14 Informant John Connor
(Address) 423 N. Conway

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 11, 1923, to Oct, 25, 1923.

that I last saw her alive on Oct, 24 1923,

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 1923

Was there an autopsy? no.

What test confirmed diagnosis? Operation @ Johns Hopkins

(Signed) David Frankel M. D.

10/26 1923 (Address) 122 W. Lee 15

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clover. Halifax Co. Va.

DATE OF BURIAL: Oct 28 1923

20 UNDERTAKER: John H. Toadvine

ADDRESS: Burial Permit Clerk

Robert E. Harrison,

Cor.—1-12-23—M&T—100 Bks.

D 80297 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80297

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 918 N. Calhoun St., 16 WARD)

2-FULL NAME Baby Thomas

(a) RESIDENCE NO. 918 N. Calhoun St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
			21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none (Infant) 0D
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER Jeanette Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Thomas
(Address) 918 N. Calhoun St.

15 Filed OCT 27 1923, 192 Robert P. Garrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ilio-Colitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hennessy, M. D.
(Coroner.)

Oct. 24, 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Coburn	Oct 26 1923

20 UNDERTAKER Jas. A. Dennis ADDRESS 217 Gorsuch

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 80298 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80298

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 N. Monroe ST. 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Neville Clark

(Residence in Baltimore: No. 2613 N Monroe St., St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH INKPADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 16 (Day), 1863 (Year)

7-AGE, 60 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Type Compositor
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John S. Clark

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Neville

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert E. Worman

(Address) 728 Newington Ave.

15-

Filed OCT 27 1923 191....

Registrar.

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 26 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from May 17 1923, to Oct 26 1923, that I saw h[illegible] alive on Oct 26 1923, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency acuten.

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis Rheumatic ?

(Duration) 2 yrs. ? mos. ....ds.

(Signed) Thomas Neil Wiley M. D.

Oct 26, 1923 (Address) Lansdowne Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Hebrew Cem. DATE OF BURIAL, 10/27, 1923

20-UNDERTAKER David Sondheim ADDRESS 118-20 W. 2nd Royal Ave

Cor.—1-12-23—M&T—100 Bks. 1111119

D 80299 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) 1 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Kandes

(a) RESIDENCE No. 921 Michigan St. Toledo Ohio (St.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gost Kandes

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Pete Cominos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER ----Sherinns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Johns Hopkins Hospital
(Address)

15 Filed OCT 27 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Autopsy at hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Collier (Coroner.) M. D.

10/26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toledo Ohio — DATE OF BURIAL 10/27 192?

20 UNDERTAKER H E Stughes — ADDRESS 1st & Broadway

Robert P. Harrison, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80300 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80300

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Park Ave St.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Simpson

(a) RESIDENCE. No. 1933 Park Ave. 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Elias Lacy Simpson

6 DATE OF BIRTH (month, day, and year) Sept. 6 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md U.S.A.

PARENTS

10 NAME OF FATHER Frederick Ballard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md. U.S.A.

12 MAIDEN NAME OF MOTHER Mary Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York N.Y. U.S.A.

14 Informant Mrs Edna Cugle
(Address) 1933 Park ave.

15 Filed . 19 Registrar

OCT 27 1923

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923, to Oct. 26, 1923, that I last saw her alive on Oct. 26, 1923, and that death occurred, on the date stated above, at 5-55 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dorne M. D.

10/26, 1923 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 26 '23
20 UNDERTAKER	ADDRESS
Henry J. Jenkins & Sons Co	Orchard & Mulberry Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE BELOW THIS LINE FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80301 D 80301

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1560 Carswell ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ina Minnie Hobbey

(Residence in Baltimore: No. 1560 Carswell St. in Baltimore Ligtsys. mos. ds.)

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particularly careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ...Unknown...., 24, 1849
(Month) (Day) (Year)

7-AGE, 73 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, James Hinds

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Kabalas

13-BIRTHPLACE OF MOTHER (State or Country), Ehyland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Albert Anthony

(Address) 1560 Carswell St.

15-

Filed ..... 191.....

Registrar.

Robert P. Harrison,
OCT 27 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 15 1923, to October 25 1923, that I saw h.r alive on October 24 1923, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of the heart

(Duration) yrs. mos. ds.

(Signed) Evan P. Whitehurst M. D.

October 25th 1923 (Address) 1615 Gordon ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	Oct 27, 1923
20-UNDERTAKER	**ADDRESS**
Geo. F. Ruth	1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 80302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80302

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 S. Carroll Town Ave ST., 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Frazer

(a) RESIDENCE NO. 46 S. Carrollton Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? 69 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Richard B. Frazer

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of Industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. William F. Frazer

(Address) 46 S. Carrollton Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 26 1923

17 I HEREBY CERTIFY, That I attended deceased from August 25 1923 to Oct 26 1923

that I last saw her alive on Oct 26th 1923

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary): Marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. E. Flook M. D.

Oct 27 1923 (Address) 1301 E Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Oct 29 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert F. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D 80303 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80303

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1331 Hillman ST., 9 WARD)

2-FULL NAME Henry Streb

(a) RESIDENCE No. 1331 Hillman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Helen Streb

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
about	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed in

(b) General nature of industry, business, or establishment in which employed (or employer) Paper box factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Helen Streb (Address) 1331 Hillman St

15 Filed ....., 19 ..... Registrar Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-1, 1923 to 10-26, 1923,

that I last saw h/m alive on 10-22, 1923,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Multiple Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. Krause, M. D.

10/26/23 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Oct. 29, 1923

20 UNDERTAKER Henry Horck & Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80304

D 80304

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 N Calvert ST., 17 WARD)

2-FULL NAME William H Streett.

(a) RESIDENCE NO. 2218 N Calvert ST., WARD The Rocks Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A Mac Atee

6 DATE OF BIRTH (month, day, and year) Oct 2, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fertilizer Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) The Rocks-Hartford Co Maryland

PARENTS

10 NAME OF FATHER John Joshua Streett

11 BIRTHPLACE OF FATHER (city or town) Hartford Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine M Waters

13 BIRTHPLACE OF MOTHER (city or town) ------- (State or country) Maryland

14 Informant (Address) Mrs Martha A Streett Fallston Hartford Co Md.

15 OCT 27 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18th 1923 to Oct. 27th 1923, that I last saw h alive on Oct. 27th 1923, and that death occurred, on the date stated above, at 1A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Endarteritis

(duration) 10 yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus Ch Dame, M. D.

10/27/1923 (Address) 3014 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 10-29-1923

20 UNDERTAKER: Henry W Meare & Son — ADDRESS: 805 N Calvert St

Record of Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80305

CERTIFICATE OF DEATH.

D 80305

1-PLACE OF DEATH University Hospital — REGISTERED NO. 179

CITY OF BALTIMORE: (No.) Cor. Lombard & Greene Sts. (WARD) 11a

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Spero Jr

(a) RESIDENCE NO. 634 Druid 12 ST., WARD Wash. D. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child.

6 DATE OF BIRTH (month, day, and year): Oct 26 1919.

7 AGE — Years: 4 yrs — Months: Oct — Days: 26. — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington. D. C.

PARENTS

10 NAME OF FATHER: Jorge Spero.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Mary Diesbo.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: Parental Cards — (Address)

15 Filed . . . 19 . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1923 to Oct 26 1923

that I last saw h[illegible] alive on Oct 26 1923

and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Secondary Burns. D.
Back, Thighs, Buttocks.
Chest, left arm & hand

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests -

(Signed) James D White M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Oct 28 19 [illegible]

20 UNDERTAKER: Louis Heemann — ADDRESS: 925 Broad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 27 1923

Burial Permit [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80306

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 S. Charles ST.: 23 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George S. Wilson

(a) RESIDENCE. No. 2034 S. Charles ST., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seaford Del.

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Seaford Del.

12 MAIDEN NAME OF MOTHER Eunice Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Seaford Del

14 Informant Mrs Annie Thaler
(Address) 1426 Patapsco St

15 Filed OCT 27 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1923, to Oct. 26, 1923, that I last saw h alive on Oct 26, 1923, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

1 Myocardial Degeneration

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell, M. D.

Oct. 26, 1923 (Address) 1427 Fillmore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Oct 29 1923

20 UNDERTAKER: A. Howard Evans ADDRESS: 1428 S. Charles St

Spec.—1-10-21 M&J 1500 Bks.

D 80307 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80307

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Gutman Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Goenell

(a) RESIDENCE NO. 612 Gutman Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Sinclair B Goenell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Irene Krumbholz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Sinclair B Goenell

(Address) 612 Gutman Ave

15 Filed OCT 27 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Oct 26, 1923,

that I last saw h[illegible] alive on Oct 26, 1923,

and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Foramen Ovale Not Closed

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V K [illegible] Fair, M. D.

(Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Oct 27 1923

20 UNDERTAKER Lou Cook ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

80308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80308

CERTIFICATE OF DEATH.

124 D 80308

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Scott

(a) RESIDENCE NO. 565 Mosher St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Oct 30 1905

7 AGE — Years: 17 — Months: 11 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Julius Parran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rosie Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Record (Address): John Hopkins Hosp.

15 Filed ..... , 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Oct 25, 1923, that I last saw h[illegible] alive on Oct 25, 1923 and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of Liver

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes What test confirmed diagnosis? Clinical Course

(Signed) E A Duncan, M. D.

10/26, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvert Co Md. DATE OF BURIAL: Oct 27 1923

20 UNDERTAKER: R L Gross ADDRESS: 1405 McElderry

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓

D 80309

CERTIFICATE OF DEATH.

D 80309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Longwood Road) (WARD) 27

2-FULL NAME Mary Elizabeth Carney

(a) RESIDENCE NO. 115 Longwood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

5. 45 pm

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of William F. Carney

6 DATE OF BIRTH (month, day, and year) March 4, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hereford (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER William Tipton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto - Co - Md

12 MAIDEN NAME OF MOTHER Easter Rankin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant F. Anna Carney

(Address) 115 Longwood Road.

15 Filed , 19 ROBERT P. KRAUTER Registrar

OCT 28 1923 Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1923, to Oct. 26, 1923,

that I last saw h-r alive on Oct. 26, 1923,

and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH was as follows*:

Cerebral Apoplexy

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Austin T. Robinson M. D.

10/27 1923 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct. 29 1923

20 UNDERTAKER Jas B Spence — ADDRESS 1025 N Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16727 D 80310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 24 WARD) 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gabriel Solomon

(a) RESIDENCE NO. 1739 Williams St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Grace Solomon

6 DATE OF BIRTH (month, day, and year): Apr 16 18 62

7 AGE: Years 60 Months 6 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Record Johns Hopkins Hosp

15 Filed OCT 28 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Oct 27, 1923

that I last saw him alive on Oct 27, 1923

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Mass in Mediastinum

Probable Empyema

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 1739 Williams st

Did an operation precede death? No Date of Oct 25-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Mackay, M. D.

10-27-1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Oct. 30 1923

20 UNDERTAKER: Wm Cook & E. H. Cook — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80311 ✓

D 80311

CERTIFICATE OF DEATH.

Registered No. 15 21

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mallon

(a) Residence No. 1613 Gilmor st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 years Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1886

7-AGE. 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) New York

PARENTS

10-NAME OF FATHER, James Mallon

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12-MAIDEN NAME OF MOTHER, Mary Boyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed OCT 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 28 1922 to Oct. 26 1923

that I last saw him alive on Oct. 26 1923

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum - X-ray

(Signed) L. A. Lally M. D

10-26 1923 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Spring Hill	Oct 27 1923

20-UNDERTAKER, Wm Cole Sons

ADDRESS Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80312

CERTIFICATE OF DEATH.

188-003 D 80312

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

2-FULL NAME Eleanor S. Brooks

(a) RESIDENCE NO 2019 E. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year) Dec 13 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Jacob Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Irene Levin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.A.

14 Informant: Jack Lewis
(Address): 1439 E Balto St

15 Filed OCT 28 1923 ROBERT P. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Spinal Cord Injury- Cervical region
(Struck by autotruck; inquest to be held Oct. 29/23)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Kaufman, M. D.
(Coroner.)

10/27/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Road — DATE OF BURIAL: 10/28 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

INSTRUCTIONS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80313

CERTIFICATE OF DEATH.

44 D 80313

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 Whitelock Street St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Rubinstein

(a) Residence No. 936 Whitelock St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Israel Rubinstein

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 61 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Abraham Liskind

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Ida Liskind

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 Eastaw Street

15- Filed OCT 26 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-26-23

17- I HEREBY CERTIFY, That I attended deceased from July 4th, 19 23 to Oct 26, 19 23

that I last saw h. alive on Oct 20 19 23

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach, malignant Cystic papilloma of ovary,

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystic papilloma of intestines (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-ray

(Signed) R. A. Michelsen M. D.

, 19 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holrem Southern Cem

DATE OF BURIAL, 10/28 19 23

20-UNDERTAKER Jack Lewis

ADDRESS 1439 Eastaw Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80314 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001 D 80314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2426 Callow ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leon Levinsohn

(a) Residence No. 2426 Callow ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (~~Write the word.~~) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Shana Levinsohn

6-DATE OF BIRTH (month, day and year) ——

7-AGE. 70 yrs. — mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer). Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

11- (Informant) Nathan Levinsohn

(Address) 5704 Belbourne ave.

13- Filed OCT 28 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-28-23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20 1923 to Oct. 27 1923

that I last saw him alive on Oct. 27 1923

and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchiectasis & Pulmonary Emphysema

(Duration) 18 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) N. Abarr M. D.

, 19 (Address) 210 E. Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Jewish Southern ave

DATE OF BURIAL, 10/28 19.. 23

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80315

CERTIFICATE OF DEATH.

101-001 ✓ D 80315

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1711 N Monroe St St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elyria Walder

(a) Residence No. 1711 N Monroe St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 13-1907

7-AGE. 15 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Needle

(b) General nature of Industry, business, or establishment in which employed (or employer). Art Work

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Max Walder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Bessie Goldberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 Eutaw St

15- Filed OCT 28 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/27/23

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1923 to Oct 27 1923, that I last saw h. alive on Oct 27 1923, and that death occurred, on the date stated above, at 2.30 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) 6 yrs. 0 mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Chenoweth M. D.

, 19 (Address) 1730 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 10/28 1923

20-UNDERTAKER, Jack Lewis 1439 Eutaw St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80316

CERTIFICATE OF DEATH.

74-001 V

D 80316

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Mosher ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wm Godman

(a) RESIDENCE NO. 2700 Mosher St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Godman

6 DATE OF BIRTH (month, day, and year) May 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Samuel Godman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Maggie Godman

(Address) 2700 Mosher St.

15 Filed . 19 Registrar

OCT 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 . 1923 . to Oct 26 . 1923 .

that I last saw him alive on Oct 25 . 1923 .

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Right Side Hemiplegia

(duration) yrs. 8 mos 2 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam.

(Signed) John A. Wieland M. D.

Oct 28 1923 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 29, 23
20 UNDERTAKER	ADDRESS
Wm Tuckerman Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Dr. J. N. Braband

1219 Poplar Grove St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80317

CERTIFICATE OF DEATH.

74-001 D 80317

1-PLACE OF DEATH 1540 N. Broadway

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1540 N. Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Emma Hortman

(a) RESIDENCE No. 1540 N. Broadway ST., 8 WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word) Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~Husband of~~ (or) WIFE of Alfred M. Hortman

6 DATE OF BIRTH (month, day, and year) Apr 23-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Nurse wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Vermont Dec.

PARENTS

10 NAME OF FATHER Thomas J Kinney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dec.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie M Dorman

(Address) 1540 N Broadway

15 Filed OCT 28 1923 ROBERT N. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2 1921 to Oct 27 1923.

that I last saw her alive on Oct 27 1923.

and that death occurred, on the date stated above, at 12-30 p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Salpingitis.

Chronic Bronchitis

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ~~ds.~~ one da.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) C C Macdonald M. D.

OCT 27, 1923 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Oct 29 1923

20 UNDERTAKER Wm J Pickerings ADDRESS North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80318

CERTIFICATE OF DEATH.

12 D 80318

1-PLACE OF DEATH Butler-Pillsmans

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724 N Charles St. 15 WARD)

2-FULL NAME David Hans Blanks

(a) RESIDENCE NO. 2711 Allendale Rd ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret C. Blanks

6 DATE OF BIRTH (month, day and year): Nov. 11 1876

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): 09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Blanks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Sarah A Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Va

14 Informant: Mrs. Margaret Blanks

(Address) 2711 Allendale Rd

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Oct 27, 1923, that I last saw him alive on Oct 27, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia Influenza

(duration) 3 wks yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 903 K St Norfolk Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno L Fentress M. D.

(Address) 2724 Nelson Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Oct 30 1923

20 UNDERTAKER: Wm Tickner & Sons ADDRESS: Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 80319

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Guyon Oak St. 28 WARD)

2-FULL NAME Andrew Hamilton

(a) RESIDENCE NO. 3920 Guyon Oak St. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose B Hamilton

6 DATE OF BIRTH (month, day, and year) Oct 1 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Orr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Rose B. Hamilton

(Address) 3920 Guyon Oak Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Oct 26, 1923, that I last saw him alive on Oct 25, 1923 and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Bronchitis and Old age

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Carcinoma of Face

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) A. C. Smith M. D.

(Address) 4509 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct 29 1923

20 UNDERTAKER Wm J Kieffer & Sons — ADDRESS North Ave

OCT 29 1923 ROBERT R. KRAUTER, BURIAL PERMIT CLERK

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 D 80320

D 80320

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 Maryland Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Shauck

(a) RESIDENCE. NO. 2742 Maryland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A Shauck

6 DATE OF BIRTH (month, day, and year) June 17th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Charles A Shauck
(Address) 2742 Maryland Ave

15 Filed . 19 ROBERT R. KRAUTER Registrar
OCT 28 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25th. 1923. to Oct 26th. 1923 that I last saw h alive on Oct 26th. 1923, and that death occurred, on the date atated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W A Faur M. D.

10/27/23 . 19 (Address) 42 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct. 29. 1923 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80321

CERTIFICATE OF DEATH.

101-001 ✓

D 80321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 E. Eager ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Taylor

(a) RESIDENCE. No. 1827 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Taylor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Isaac Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marg. Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Margaret Taylor

(Address) 1827 E. Eager St.

15 Filed OCT 28 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1923, to Oct. 25, 1923, that I last saw him alive on Oct. 25, 1923, and that death occurred, on the date stated above, at 7.55 P. m.

The CAUSE OF DEATH* was as follows:

Labar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

(Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 10/28/1923

20 UNDERTAKER: Jos. H. Dennis — ADDRESS: 1213 Fremont

OCT 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 80322

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 Mc Henry St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Frances Hebler

(a) Residence No. 1409 Mc Henry St., Ward 19th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. - mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Anthony Hebler.

6-DATE OF BIRTH (month, day and year) Dont Know

7-AGE, 5+ yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Carl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Wm Hebler Son

(Address) 314 S. Calhoun St.

15- Filed OCT 28 1923 Registrar. ROBERT P. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). October 26/23

17- I HEREBY CERTIFY, That I attended deceased from September 15 1923, to Oct 26, 1923, that I last saw her alive on Oct 26, 1923, and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Hypertrophy + Enlarged Heart.

10 — (Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

Dont Know (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Costello, M. D.

, 19 (Address) 335 E 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, Oct 29th 1923

20-UNDERTAKER. A. Jones ADDRESS, 111 S. Gilmor St

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80323
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

X 90

D 80323
REGISTERED NO.

CITY OF BALTIMORE: (No. 552 University Parkway 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Follette York

(a) RESIDENCE. NO. 552 University Parkway WARD. (Cleveland Ohio)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mary Read York

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prof. Auto. Business

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cleveland Ohio U.S.A.

PARENTS

10 NAME OF FATHER Barney York

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clyde Ohio U.S.A.

12 MAIDEN NAME OF MOTHER Julia Harkness

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bellevue Ohio U.S.A.

14 Informant Mrs. J. C. Read
(Address) 552 Univ. Parkway

15 Filed . 19 Registrar
OCT 28 1923 ROBERT R. KRAETER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923, to Oct. 27 1923, that I last saw h~~im~~ alive on Oct. 26th 1923, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Coronary Artery

(duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dorsey M. D.

10/27, 1923 (Address) 3014 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 29 1923

20 UNDERTAKER	ADDRESS
Henry H. Jenkins & Son Co	Orchard & Mulberry Sts

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80324

D 80324

CERTIFICATE OF DEATH.

160

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE. (No. 2001 Wash Blvd St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melarde Sutton

(a) Residence No. 2001 Wash Blvd St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Sept 28 23

7-AGE, ... yrs. ..... mos. 31 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Bay View Hosp.

PARENTS.

10-NAME OF FATHER, Sutton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mildred Lutz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mrs Lutz

(Address) 2001 Wash Blvd

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 27 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 23 to Oct 27 1923

that I last saw him alive on Oct 27 23 and that death occurred, on the date stated above, at 4.35 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? None

(Signed) John G Schwentker M.D.

, 192 (Address) 126 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Oct 29, 1923
20-UNDERTAKER	ADDRESS
Knell & Sons	1129 W Baltimore

WHITE CLERK, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80325

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 80325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1927 Penrose Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice C. Cavey

(a) Residence No. 1927 Penrose Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph J. Cavey

6-DATE OF BIRTH (month, day and year) Feb. 14 1849

7-AGE, 74 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9-BIRTHPLACE (city or town) Frostburg (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Sloane

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Joseph J. Cavey

(Address) 1927 Penrose Ave

15- Filed ..... 19.. ROBERT R. KRAUER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 28 192[illegible]

17- I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Oct 27, 1923 that I last saw h[illegible] alive on Oct 27th, 1928, and that death occurred, on the date stated above, at 1.50 A.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj Kradin, M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Harrisonburg, Va. DATE OF BURIAL, Oct 29, 1923

20-UNDERTAKER, Ralph B Cook ADDRESS 1003 N Eutaw St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks. 80327 Richard D Newman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80326

CERTIFICATE OF DEATH. 188-003

REGISTERED NO. D 80326

1-PLACE OF DEATH On way to University Hosp

CITY OF BALTIMORE: (No. Eldridge Rd ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R D Newman

(a) RESIDENCE NO. Univ Maryland Frat House WARD Smithsburg Md
(Usual place of abode) 613 N Calhoun St (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13 - 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Medical Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown
(State or country) Md

PARENTS

10 NAME OF FATHER Thos L Newman

11 BIRTHPLACE OF FATHER (city or town) Hagerstown
(State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Delamater

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown
(State or country) Md

14 Informant R D Newman
(Address) Smithsburg Md

15 Filed OCT 29 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Auto Accident
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 1 ds.

(Signed) G. C. Slade, M. D.
(Coroner)
Oct 29 1923 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smithsburg Md	Oct 29 1923
20 UNDERTAKER Robt Kinzer	ADDRESS Bray

If death occurred in a hospital or institution, give its NAME instead of street and number. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. 80324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80327 D 80327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ... St., 11 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bowles

(a) RESIDENCE NO. Middletown Md St. ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 14 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 25, 1870

7 AGE: Years 53 Months 3 Days 3 If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Bowles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mc Groon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant ... (Address) ...

15 Filed ... 19 ... Registrar

OCT 29 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1923

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1923, to Octo 28, 1923, that I last saw h[illegible] alive on Octo 28, 1923, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

1 Hypertrophy of Prostate Gland

2 Chronic Nephritis

3 Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? No clinical

What test confirmed diagnosis? ...

(Signed) James Hubert Wolfarth M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Md. DATE OF BURIAL: 10 27 1923

20 UNDERTAKER: E & B Hauk ADDRESS: 110 E West St

Spec.—1-10-21—M&T—1500 Bks.

D 80328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 80328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4890 Reisterstown Road ST., 28 WARD)

2-FULL NAME Mary Elizabeth Acton

(a) RESIDENCE NO. 4890 Reisterstown Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elijah Acton

6 DATE OF BIRTH (month, day, and year) April 15 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	77	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mr. Jordan

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass

12 MAIDEN NAME OF MOTHER Marilda Townsend

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Laura E. Stevens
(Address) 4890 Reisterstown Road

15 Filed ..... 19 .....

ROBERT R. KRAUTER
Registrar

OCT 29 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 19 23 to Oct 28 19 23,

that I last saw h alive on Oct 19 19 23,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. S. Jon M. D.

Oct 28 19 23 (Address) 720 N Norths

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 31st 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80327 ~~D 80329~~ X 135 D 80329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 9 WARD

CITY OF BALTIMORE: (No) ST.,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Kaelin

(a) RESIDENCE NO. 1341 N. Eden ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mo. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Laura

6 DATE OF BIRTH (month, day, and year) Aug 30-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Henry Kaelin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fracella Carbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant (Address) Dr Dorsey Caulk

ROBERT P. KRANTZ
Burial Permit Clerk

15 Filed OCT 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25-1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1923, to Oct 25, 1923.

that I last saw him alive on Oct 25, 1923

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic

(Signed) Eugene L. Flippin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Oct. 19 23

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1002

118 D 80330

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 768 W. Hamburg ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Reinhart

(a) RESIDENCE NO. 768 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Frederick Reinhart

6 DATE OF BIRTH (month, day, and year) Feb. 26 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert J. Reinhart (Address) 768 W. Hamburg St

15 Filed OCT 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1923 to Oct 26 1923.

that I last saw her alive on Oct 26 1923, and that death occurred, on the date stated above, at 6 20 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Intestine

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Vomiting Feces.

(Signed) [illegible], M. D.

10/26 1923 (Address) 517 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Oct 30 1923.

20 UNDERTAKER James Digman & Son — ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80331

D 80331

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 11 WARD)

2-FULL NAME T. Rowland Thomas

(a) RESIDENCE NO. 1118 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ella Thomas

6 DATE OF BIRTH (month, day, and year) March 7, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's County Md.

PARENTS

10 NAME OF FATHER Dr James J Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nattie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary L Thomas
(Address) 1118 N Calvert St

15 Filed OCT 29 1923, 19 ..... Registrar

ROBERT R. KRAUTER
CHIEF CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1923, to October 27, 1923, that I last saw h alive on October 27, 1923, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, acute; Cholelithiasis (acute exacerbation of chronic infection)

(duration) yrs. 6 + mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of stomach

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-22/23 Removal of Gall Bladder

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A B Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct 29 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80332

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3332 Frederick Ave ST. 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Collins

(a) RESIDENCE. NO. 3332 Frederick Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leroy Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen W. Herrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Helen W. Collins (Address) 3332 Fredk. Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923, to Oct 28, 1923, that I last saw h live on Oct 28, 1923 and that death occurred, on the date stated above, at 2300 A.M.

The CAUSE OF DEATH* was as follows:

Spasms & convulsions from gastric disturbance

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None ate of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Samuel B. Slagle, M. D.

, 19 (Address) 3326 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 29 1923

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 29 1923 ROBERT P. KRAUTER BURIAL PERMIT CLERK

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable Cause of Death

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80333

CERTIFICATE OF DEATH.

74-001

D 80333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 W. Barre St. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Washington. (C)

(a) RESIDENCE No. 522 W. Barre St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Walter Johnson. (C)
(Address) 522 W. Barre St.

15 Filed OCT 29 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Oct, 29, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion ct

DATE OF BURIAL Oct 29 192

20 UNDERTAKER I. H. Brown and Son

ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 80334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 100-001

CITY OF BALTIMORE: (No. 930 Warner ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Alonzo Gaines

(Residence in Baltimore: No. 930 Warner St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 13, 1923 (Month) (Day) (Year)

7-AGE, 4 yrs. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Gaines

(Address) 930 Warner

15-

Filed OCT 29 1923, 191.. ROBERT R. KRAMER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1923, to Oct 27 1923, that I saw h alive on Oct 26 1923, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Rachitis

(Duration) yrs. 3 mos. ds.

(Signed) H. S. McCord M. D.

10/27, 191.. (Address) 1001 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct

DATE OF BURIAL, Oct 29, 191..

20-UNDERTAKER I. D. Brown & Son

ADDRESS 1011 W. Mondg St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80335

91-002

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 St Paul St ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pere Lethbury Wicke

(a) RESIDENCE NO. 920 St. Paul St. ST., 11 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Henrietta Catherine Wicke

6 DATE OF BIRTH (month, day, and year) 1837-8-14

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Judge

(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown

(State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Joseph Wicke 4th

11 BIRTHPLACE OF FATHER (city or town) Chestertown

(State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth C. Chamber

13 BIRTHPLACE OF MOTHER (city or town) Chestertown

(State or country) Kent Co Md

14 Informant Dr Walter Wicke

(Address) Brooklandville Md

15 Filed OCT 29 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17

I HEREBY CERTIFY, That I attended deceased from ....., 192.., to Oct 27th, 1923,

that I last saw h alive on Oct 27th, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senile Debility Acute

1 hr

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C B Garnett, M. D.

, 19 (Address) 24 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Oct 29 1923

20 UNDERTAKER Henry W. Jenkins Sons

ADDRESS Orchard & McCulloh

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80336

CERTIFICATE OF DEATH.

100-001

D 80336

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poplar Ave & Hickory St. Overlea WARD) 27

2-FULL NAME Jean Marie Ballinger

(a) RESIDENCE NO Poplar Ave & Hickory ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Age should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Sept. 26/23

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXX X
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. E.Ballinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md.

12 MAIDEN NAME OF MOTHER Marie Strasburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs.Chas. Ballinger
(Address) Poplar Ave & Hickory St.

15 Filed OCT 29 1923 192 ROBERT N. KRAUTER, Registrar
Burial Permit ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Probably Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Ballin, M. D.
(Coroner)
OCT 29 1923 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Oct 29 192 3

20 UNDERTAKER H. W. Cook — ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 80337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80337

CERTIFICATE OF DEATH.

X 109-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital #1 ST.) (WARD)

2-FULL NAME Clarence Briggs.

(a) RESIDENCE NO. U.S. Marine Hospital #1 ST. WARD 2 Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE: Years 19 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman, attendant

(b) General nature of industry, business, or establishment in which employed (or employer): Seaman U.S.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portsmouth, Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self Clarence Briggs

(Address)

15 Filed OCT 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Oct. 27, 1923,

that I last saw him alive on Oct. 27, 1923,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Endocarditis, Septemia

Contributory

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) M. K. Carter M. D.

Oct 27, 1923 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Portsmouth Va.

DATE OF BURIAL 10/29 1923

20 UNDERTAKER: Fol Funeral Bro

ADDRESS 1127 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gave a history of
Tonsilitis

D 80338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 80338

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Woodyear St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James V. Fuller

(Residence in Baltimore: No. 1135 Woodyear St. St.; yrs. 4 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	single

6-DATE OF BIRTH. June 25, 1923 (Month) (Day) (Year)

7-AGE. 1 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work ..... none (Infant)
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. James H. Fuller

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Lossie Smith

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lossie Fuller

(Address) 1135 Woodyear St.

15

Filed OCT 29 1926 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 27, 1926 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute endocarditis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. C. Hemsoth M. D. (Coroner.)

Oct. 27 1926 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	10-29-26

20-UNDERTAKER Dan'l Eaton ADDRESS 476 Fremont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 12 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr James Sloan Hopkins

(a) RESIDENCE NO. 3401 Greenway Corte WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Spamer

6 DATE OF BIRTH (month, day, and year) Sept 6 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
72	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Maryland (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Joseph S. Hopkins

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Ellen Morgan

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country) Philadelphia Pa.

14 Informant Record (Address) Johns Hopkins Hosp

15 Filed OCT 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Oct 25, 1923 that I last saw h alive on Oct 25, 1923 and that death occurred, on the date stated above, at 1000 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No - Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Section.

(Signed) Thos Owen, M. D.

Oct 28 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 30 1923

20 UNDERTAKER: Henry W Mears & Son — ADDRESS: 805 N Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80340 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80340

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1720 N. Port ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stocker

(a) RESIDENCE NO. 1720 N Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary K Stocker

6 DATE OF BIRTH (month, day, and year): Dec 25 1856

7 AGE: Years 66; Months —; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary K Stocker

(Address) 1720 N. Port St

15 Filed OCT 29 1923 ROBERT R. KINGSLEY, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Oct 26, 1923, that I last saw h alive on Oct 26, 1923, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. Roberts, M. D.

Oct 27, 1923 (Address) 801 N Port St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Oct 29, 1923

20 UNDERTAKER: Robt J Lemmon Sr — ADDRESS: 1714 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D 80341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 70 WARD)

2-FULL NAME Mrs. Josephine Streiman

(a) RESIDENCE NO. 28 So Pulaski St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Streiman

6 DATE OF BIRTH (month, day, and year): Dec 5-1867

7 AGE: Years: 56 yrs | Months: 2 | Days: 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): Martin Streiman 28 So Pulaski St.

15 Filed OCT 29 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1923, to Oct. 28, 1923, that I last saw h[illegible] alive on Oct. 28, 1923, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral or Coronary Embolus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus — Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 10/27/23

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. W. Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery DATE OF BURIAL: Oct 31 1923

20 UNDERTAKER: George L Schwab ADDRESS: 2401 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80342

CERTIFICATE OF DEATH.

D 80342

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 E. Fairmount Ave. WARD) 6

2-FULL NAME Elizabeth Hoerner

(a) RESIDENCE NO. 2519 E Fairmount Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Nov. 11 - 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	6.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Bernard Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Morgenthau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Phillip Frankenberg

(Address) 2519 E Fairmount Ave

15 Filed OCT 29 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1923, to Oct. 25 1923, that I last saw h[er] alive on Oct. 25 1923, and that death occurred, on the date stated above, at 1.00 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 6. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr. M. D.

10/26 1923 (Address) 26 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 29 1923

20 UNDERTAKER George Schwab — ADDRESS 1101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80343

CERTIFICATE OF DEATH.

38 ✓

REGISTERED NO. C D 80343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 N. Wallas ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Johnson

(Residence in Baltimore: No. 304 N Wallas St.; 14 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown (Month) 1 (Day) (Year)

7-AGE, about 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Alexander Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smallwood

(Address) 304 N Wallas St

15-

Filed OCT 29 1923 191 ROBERT P. KRAUS Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1923, to Oct 25 1923, that I saw h[illegible] alive on Oct 25 1923, and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Renal Myocarditis.

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R J Young M. D.

10/26, 1923. (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, East View Spring Wood Station Va. DATE OF BURIAL, Oct 30th 1923

20-UNDERTAKER Mrs. L. A. Elliott ADDRESS 1725 Ashland

as

Spec.—1-10-21—M&T—1500 Bks.

Inf of Sherman & Virginia Palmer.

D 80344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 80344

1-PLACE OF DEATH Home. (Jessie M)

CITY OF BALTIMORE: (NO. 702 Fulton ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Palmer.

(a) RESIDENCE NO. 702 Fulton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): 10/21/23

7 AGE — Years: ..... Months: ..... Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Sherman Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Johnstown Pa.

12 MAIDEN NAME OF MOTHER: Virginia Bebo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Community Hospital Records

(Address) Fulton & Holmes Sts. Balto Md.

15 Filed OCT 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/29/23 19

17

I HEREBY CERTIFY, That I attended deceased from October 21. 1923. to Oct 28. 1923.

that I last saw him alive on Oct 28. 1923.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W Wallace Walker, M. D.

. 19 (Address) University Hospital Fulton & Holmes Sts. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem.

DATE OF BURIAL: 10/30 1923

20 UNDERTAKER: Samuel Hensley

ADDRESS 578 N Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 ✓

CERTIFICATE OF DEATH.

D 80345

D 80345

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Jackson Court St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Hickman

(Residence in Baltimore: No. 1435 Jackson Court St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day), (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Queen Annes County Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Lowe

(Address) 2411 Oak St

15-

OCT 29 1923

Filed, 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1923, to Oct 26 1923, that I saw h[illegible] alive on Oct 25 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Probably Influenza

(Duration) yrs. mos. ds.

(Signed) W. Clyde Burns M. D.

Oct 26, 1923 (Address) 211 E. 20

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Valley Cemetery

DATE OF BURIAL, Oct 29, 1923

20-UNDERTAKER Wm Robert Elliott

ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Bks.

Kentley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80346 162 D 80346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH At Home

CITY OF BALTIMORE: (No. 926 Mason ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Kentley

(a) RESIDENCE NO. 926 Mason ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/24/23

7 AGE Years Months Days: 6 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel Air. (State or country) State of Md.

PARENTS

10 NAME OF FATHER Winston Kentley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn County Va.

12 MAIDEN NAME OF MOTHER Adele Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant (Address) University Hospital records.

15 Filed OCT 29 1923, 19 ... Registrar ROBERT R. KRAUTER, Commissioner of Health.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1923, to 10/28, 1923, that I last saw h[illegible] alive on 10/28, 1923, and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No lymph Secondary cancer part of lung & Pleura.

(Signed) W Wallace Walker M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 29 1923 WM. R. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

5 5 5

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80347

CERTIFICATE OF DEATH.

118 D 80347

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 N. Carrollton Av St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo J. Bannon

(Residence in Baltimore: No. 309 N. Carrollton Av St.; yrs. 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Dec. 8, 1889 (Month) (Day) (Year)

7-AGE: 33 yrs. 10 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Michael H. Bannon

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Margaret C. Ryan

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna C. Ryan

(Address) 309 N. Carrollton Av.

15-

Filed OCT 29 1923, 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 27 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction.

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary): no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Hennessy M. D. (Coroner)

Oct. 28 1923 (Address) 2802 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Oct 30 1923

20-UNDERTAKER: F. A. Frances Son

ADDRESS: 1632 Hanover St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 80348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 161-001 D 80348

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Battery ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Day

(a) RESIDENCE. No. 1427 Battery ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/29/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hr. 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None—old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carl J Day.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret McGroarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant (Address) C. J Day. 1427 Battery ave

15 Filed OCT 29 1923 ROBERT R. KAUFFELT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 24. 1923

17 I HEREBY CERTIFY, That I attended deceased from 10.29.23 . 19 . to 10.24.23 . 19 .

that I last saw him alive on 10.24.23 . 19 .

and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

1 hour & 15 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Norris, M. D.

10.29., 1923 (Address) 107 E. west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	10/29/23
20 UNDERTAKER	ADDRESS
J J Bobey Sons	1318 Light

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80349

100-001 ✓ D 80349

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 E Lombard ST., 19 WARD)

2-FULL NAME Irene Davis.

(a) RESIDENCE NO. 1402 Lombard ST., ... WARD ..
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 18/23

7 AGE — Years: — Months: — Days: 11 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Louis Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York, N.Y. ~~Russia~~

12 MAIDEN NAME OF MOTHER: Annie Appelstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Louis Davis 1402 E Lombard st

15 Filed Oct 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1923, to Oct 29, 1923, that I last saw her alive on Oct. 28, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(over)

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary): —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? None

(Signed) Herman Seidl, M. D.

, 19 (Address) 2404 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Road

DATE OF BURIAL: Oct 29 19 23

UNDERTAKER: Mat Levinson

ADDRESS 1127 Balto st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80350

CERTIFICATE OF DEATH.

D 80350

1663 31

1-PLACE OF DEATH. JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 76 WARD)

2-FULL NAME William H. Sawyer

(a) RESIDENCE NO. Colgate, Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Only during stay in Hospital yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 19 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barabara Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) Johns Hopkins Hosp.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1923, to Oct 28, 1923, that I last saw h. alive on Oct 28 1923 and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Became generalized in hosp.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray

(Signed) R. A. Wreph, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL 10/30 1923

20 UNDERTAKER Geo M. Zenk & Son ADDRESS 811 N Wolfe St

No 2569

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and address CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 29 1923

Robert F. Garrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80351 D 80351

CERTIFICATE OF DEATH.

21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 E: Chase St ST., 1 WARD)

2-FULL NAME William Hoffmann

(a) RESIDENCE NO. 1927 E: Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Hoffmann

6 DATE OF BIRTH (month, day, and year) 1/6/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 0/3

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Hoffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina Hoffmann

(Address) 1927 E: Chase St

15 Filed 10/29 1923 Robert P. Harrison, Registrar

CT 29 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1922, to Oct. 27, 1923, that I last saw him alive on Oct 27, 1923, and that death occurred, on the date stated above, at 9.39 Pm m.

The CAUSE OF DEATH* was as follows:

Chronic Paranchymatous Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia, Erysipelas

Pulmonary Tuberculosis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? (No) Date of No

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) W. Hoffmann M. D.

10/29 1923 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER John Sellers

ADDRESS 228 Bonner

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80352

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 Esther Place ST., 76 WARD)

2-FULL NAME Anna E. Bean

(a) RESIDENCE NO. 3206 Esther Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 00 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A Bean

6 DATE OF BIRTH (month, day, and year) Sept 18-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	00	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Conrad Krebs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Geo P Hasemeier

(Address) 3209 Esther Place

15 Filed ..... 19..... Registrar

Robert P. Garrison, Burial Permit Clerk.

CT 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to Oct 27, 1923, that I last saw her alive on Oct 26, 1923, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Val. Dis. heart - Aortic Insuff. - Sclerosis

(duration) Indefinite yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Geo P Hasemeier, M. D.

Oct 29 1923 (Address) 724 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER John Meier & Son

ADDRESS Edean

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. If information is not supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp. REGISTERED NO. 25 - X 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mrs Mary Mullin

(a) RESIDENCE NO. Emittsburg Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of: James Mullin

6 DATE OF BIRTH (month, day, and year): ~~Unknown~~ 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): James Mullin Emmitsburg Md

15 Filed ....., 19 ..... Burial Permit Clerk. Registrar

CT 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1923 to Oct 29 1923, that I last saw h~~e~~ alive on Oct 29 1923, and that death occurred, on the date stated above, at 2.52 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus Transverse Myelitis Myocardial insufficiency Carcinoma of Liver & metastasis.

— (duration) 8? yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto. Md (Home)

Did an operation precede death? No Date of —

Was there an autopsy? Yes. Partial examination of G.B. region

What test confirmed diagnosis? Carcinoma of Gall Bladder with metastasis

(Signed) M. Alexander Mowery, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emittsbourgh Md. DATE OF BURIAL: Oct 29 1923

20 UNDERTAKER: Martin Fahey & Sons ADDRESS: 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80354

CERTIFICATE OF DEATH.

74-001 D 80354

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 E Monument St.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Jenkins

(Residence in Baltimore: No. 1602 E Monument St.; 34 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, exact date not known, ...
(Month) (Day) (Year)

7-AGE, approx 60 yrs
.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer plant

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Francis Abbot

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jenkins (Wife)

(Address) 1602 E Monument St.

15-

Filed OCT 29 1923, 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1923, to Oct 26 1923, that I saw h.. alive on Oct 26 1923, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage
Facial Paralysis

(Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis Hypertension uncertain

(Duration) .....yrs. .....mos. .....ds.

(Signed) R J Young M. D.

10/28, 23 (Address) 1602 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, Oct. 30, 23

20-UNDERTAKER Mrs Chas G Bailey

ADDRESS 1421 Jefferson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80355

CERTIFICATE OF DEATH.

129 D 80355

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Caladv. & Saratoga STS. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. Lemuing House 1009 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 6/22/55

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address)

15 Filed ..., 19 ... Registrar

CT 29 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/10, 1923, to 10-27, 1923, that I last saw him alive on 10/27, 1923, and that death occurred, on the date stated above, at 12.50 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis - Hypertrophy of Prostate (Benign) - Acute Retention - Chronic nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility - Exhaustion

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/22/23

Was there an autopsy? No

What test confirmed diagnosis? Laboratory - Operation

(Signed) T. W. Talley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cemetery — DATE OF BURIAL 6/30 1923

20 UNDERTAKER H. Sander Son — ADDRESS 1710 Eutaw St.

Information, with certificate—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80356

CERTIFICATE OF DEATH.

67 - 001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 S. Decker Ave ST., 1 WARD)

2-FULL NAME John Michael Everd.

(a) RESIDENCE NO. 922 S. Decker Ave ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Everd.

6 DATE OF BIRTH (month, day, and year) March 20-1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert B. Everd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Heiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis E. Everd.
(Address) 725 S. Duncan St

15 Filed OCT 29 1923 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1923, to Oct 28 1923.

that I last saw him alive on Oct 27 1923.

and that death occurred, on the date stated above, at 9 05 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
(duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Oct 29 1923 (Signed) M J McAvoy, M. D.
(Address) 839 S. Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Oct. 31 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80357

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 S. Belnord Ave. WARD 1)

2-FULL NAME Agnes Vogel.

(a) RESIDENCE NO. 510 S. Belnord Ave. WARD 1
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Vogel.

6 DATE OF BIRTH (month, day, and year) April 10-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant ..... (Address) James Vogel 510 S Belnord.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

OCT 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Oct 27, 1923, that I last saw h[illegible] alive on Oct 26, 1923, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma "intestines"

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Keller M. D.

10-29-1923 (Address) 1937 Wright

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 30 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80358

CERTIFICATE OF DEATH.

90 D 80358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1802 W. Franklin St. (WARD) 20

2-FULL NAME Marie A. Fischer

(a) RESIDENCE NO. 1802 W. Franklin ST., St WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or ~~Divorced (write the word)~~: widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Karl Fischer

6 DATE OF BIRTH (month, day, and year): Oct 28 1834

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
89	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: J. Imbel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George A. Fischer

(Address) 1802 W. Franklin

15 Filed. OCT 29 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1923 to Oct 28 1923, that I last saw her alive on Oct 28 1923, and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Myocarditis * Senile
Arteriosclerosis

(duration) Over 3 mos — ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry C. Blake, M. D.

Oct 29 1923 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 31 1923

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 217 S. Paca

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80359

101-00

D 80359

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

2-FULL NAME Paul Garland

(a) RESIDENCE NO. 516 Preston St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred About 5 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Garland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nannie Linsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed , 19 Registrar

CT 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 19 23

17

I HEREBY CERTIFY, That I attended deceased from October 20, 19 23. to October 27, 19 23, that I last saw him alive on October 26, 19 23, and that death occurred, on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Drane M. D.

10-29-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

INSTRUCTIONS: WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every question on this certificate must be answered, with the information as accurate and complete as possible. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Potocki

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-80360

CERTIFICATE OF DEATH.

107-002

D 80360

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. No ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Potocki

(a) RESIDENCE NO. 613 So Belnord ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Stephen Potocki

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Cecila Kopyczinski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Stephen Potocki (Address) c/o Belnord ave

15 Filed OCT 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1923, to Oct 29, 1923, that I last saw him alive on Oct 29, 1923 and that death occurred, on the date stated above, at 2:05 P. m.

The CAUSE OF DEATH* was as follows:

Acute lobar Pneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Otitis Media (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? At patient's home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Casper Koskoff, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Oct 31 1923

20 UNDERTAKER J W Ozgeuski ADDRESS 1930 Eastern av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 80361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 80361

1-PLACE OF DEATH

City of BALTIMORE: (No. 1710 Brunt St. 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and DIE-Out No. 18.)

2-FULL NAME..... Jessie Locke

(Residence in Baltimore: No. 1710 Brunt St. St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: about (Month) (Day) 1897 (Year)

7-AGE: about 26 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE. (State or Country): N. Carolina

PARENTS

10-NAME OF FATHER: Henry Young

11-BIRTHPLACE OF FATHER. (State or Country): N. Carolina

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER. (State or Country): N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Locke.

(Address) 1710 Brunt St

15-

Filed, ... 192.....

OCT 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 27, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Lead Poisoning

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Heimsath M. D. (Coroner.)

Oct. 29 1923 (Address) 28 E. Lexington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Charlotte Hall Md. Chas Co

DATE OF BURIAL: 10/31 1923

20-UNDERTAKER: Jno H Tradewin

ADDRESS: 142 N Hill St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Hattie Johnson)

D 80362

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 80362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 E Madison ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Hetty Johnson

(a) RESIDENCE NO. 1509 E. Madison ST., VII WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Female	Colord	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~August 9~~ March 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1509 E madison st Balto m'd

PARENTS

10 NAME OF FATHER morris Johnson

11 BIRTHPLACE OF FATHER (city or town) St mays (State or country) Co m'd

12 MAIDEN NAME OF MOTHER mamie Long

13 BIRTHPLACE OF MOTHER (city or town) St mayes (State or country) Co m'd

14 Informant morris Johnson

(Address) 1509 E madison st

15 Filed ..... 19 ..... RUDOLPH R. KRAUTER, Registrar

OCT 30 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29. 1923 to Oct. 29. 1923

that I last saw her alive on Oct. 28. 1923

and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Threting (duration) — yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. J. Lebold, M. D.

, 19 (Address) 1008 Pigsuth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER Edward Bryson

ADDRESS 1031 Orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80363 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ D 80363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Dolphin ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah R. Biggs

(a) RESIDENCE NO. 721 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 21st, 1848

7 AGE — Years: 75 Months: 0 Days: 3 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pikesburg Va

PARENTS

10 NAME OF FATHER: Joseph R. Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mrs. Lucy Jones 721 Dolphin

15 Filed ....., 19 .....

RUBEN R. [illegible] Burial Permit Clerk

Registrar

OCT 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13th, 1923 to Oct 26th, 1923, that I last saw h alive on Oct. 26th, 1923, and that death occurred, on the date stated above, at 10:35 a.m.

The CAUSE OF DEATH* was as follows:

Cor. Pulmonale

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Louisville

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elliott, M. D.

, 19 23 (Address) 721 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: Oct 30 1923

20 UNDERTAKER: Mrs R A Elliott — ADDRESS: 725 Ashland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80364

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 80364

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Manchester Apts

CITY OF BALTIMORE: No. Broadway & Madison ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Block

(a) RESIDENCE. No. Broadway & Madison ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 25—1900

7 AGE — Years: 22 Months: 10 Days: 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer): 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: Frank E. Block

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Jennie Rubin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E. Baltimore Street

15 Filed . 19 Registrar

OCT 30 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. , 1922 , to Oct. 29 , 1923 , that I last saw h.r alive on Oct 29 , 1923 , and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of limbs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) ✓ Frederick Leutz, M. D

Oct 29 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 10/30 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Sophia · W. Domschke /

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80365

74-001

D 80365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 E Lehman St.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia W. Domschke

(Residence in Baltimore: No. 1835 E. Lehman St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., ... (Month) Sept. (Day) 19, (Year) 1860

7-AGE, 63 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. Seale

(Address) 1835 E. Lehman St.

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

OCT 30 1923
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1923, to Oct 29 1923, that I saw h.. alive on Oct 28 1923, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chron. Bronchitis

Arteriosclerosis (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Chas. B. Lehman M. D.

Oct 29, 1923 (Address) 718 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov. 1, 1923
20-UNDERTAKER	ADDRESS
Henry Lutz	1203 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80366 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80366

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 Harrison Ave St. 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Eisenberger

(a) RESIDENCE NO. 2710 Harrison Ave WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 0 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Eisenberger

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Eisenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Eyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Wertz (Address) 2710 Harrison Ave

15 Filed OCT 30 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1923

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1923, to October 29, 1923, that I last saw him alive on October 28, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen C. Beetham, M. D.

10-29, 1923 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct 31 1923
20 UNDERTAKER Wm Tickner & Sons	ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 80367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80367

112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. F. Gailey Boyce.

(a) RESIDENCE NO. 508 S. E. 2nd St., Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Boyce

6 DATE OF BIRTH (month, day, and year) Dec 9/73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumber Insptr.
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Boyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizd —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Augusta Boyce Wife (Address) 508 East Ave.

15 Filed OCT 30 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion

(duration) yrs. mos. 1 hrs. ds.

to Dil Heart

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 hrs. ds.

(Signed) Geo Eastow Bayliss M. D.

(Coroner)

Oct 30, 1923 (Address) 143 N Bway

*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov 1 1923

20 UNDERTAKER Philip Herwig

ADDRESS 3016 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 80368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80368

188-803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1166 Sargeant St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Legg

(Residence in Baltimore: No. 1166 Sargeant St.; yrs. 7 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colule	Single

6-DATE OF BIRTH, November 30 1913
(Month) (Day) (Year)

7-AGE. 9 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Nathaniel Legg

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Gertrude Randall

13-BIRTHPLACE OF MOTHER, (State or Country). Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Nathaniel Legg

(Address) 1166 Sargeant St

15- Filed OCT 30 1923 Registrar. HUBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident

Multiple Fractures

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Geo Clinton Blade M. D.
(Coroner.)

Oct 29 1923 (Address) 1426 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Lawn	Oct 31st 1923
20-UNDERTAKER. Jos E Lawrence & Son	ADDRESS 701 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80369 — CERTIFICATE OF DEATH. — X 4465 80369

1-PLACE OF DEATH Mercy Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Calvert & Saratoga STS. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Freeman Stecker

(a) RESIDENCE NO. State College - Penn. STS. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 23 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Stecker

6 DATE OF BIRTH (month, day, and year) 6/3/67

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
56	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. State College

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Henry Stecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Zeffers

13 BIRTHPLACE OF MOTHER (city or town) Newport (State or country) R. I.

14 Informant (Address) Hospital Records

15 Filed ..., 19 ... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk. OCT 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/6, 1923, to 10/29, 1923, that I last saw h/m alive on 10/29, 1923, and that death occurred, on the date stated above, at 550 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) 1 yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? Penn.

Did an operation precede death? Yes Date of 10/16/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Kurt Holley, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL State College Pa — DATE OF BURIAL Nov 2 1923

20 UNDERTAKER George F. Smith — ADDRESS ...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80370 CERTIFICATE OF DEATH. 161-001 D 80370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Harman St., 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Samuel J. & Amelia Granger

(a) RESIDENCE No. 1605 Harman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28/1923

7 AGE Years Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel J. Granger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Amelia Yukyte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Samuel J. Granger (Address) 1605 Harman Ave

15 Filed OCT 30 1923 19 ROBERT A. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Oct 28, 1923; that I last saw h alive on Oct 28, 1923; and that death occurred, on the date stated above, at 7-10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

16 Hrs. Interval

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mal. Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. L. Campbell, M. D.

28, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL State Dept. of Health

DATE OF BURIAL OCT 30 1923 19

20 UNDERTAKER Dr. Romer

ADDRESS Commissioner Health,

Per. Wm. F. Woodall

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80371

CERTIFICATE OF DEATH.

100-60 D 80371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 10 WARD)

2-FULL NAME Margaret Quick

(a) RESIDENCE NO 822 Stirling St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7 weeks		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Willie Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Johns Hopkins Hospital
(Address)

15 Filed OCT 30 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(Autopsy at Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Collins, M. D.
(Coroner.)

Oct. 26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSP

DATE OF BURIAL: OCT 30 1923 192

20 UNDERTAKER: Per. Wm. E. WOODALL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80372

D 80372

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

7.23

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Cecil Apartments N. Eutaw ST., 11 WARD)

2-FULL NAME Rachel Brooks Carey

(a) RESIDENCE NO. Cecil Apartments N. Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced (~~HUSBAND~~ of) (or) WIFE of George Leiper Carey

6 DATE OF BIRTH (month, day, and year) May 6. 1859

7 AGE — Years: 64 — Months: 5 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry Phelps Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Maryland

12 MAIDEN NAME OF MOTHER: Rachel H. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Maryland

14 Informant: Miss Kate Brooks
(Address) Cecil Apartment

15 Filed OCT 30 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1923, to Oct. 29, 1923, that I last saw her alive on Oct. 29, 1923, and that death occurred, on the date stated above, at 7.30 h. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis
Valvular heart disease
(following rheumatism)
(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral embolism (Sudden)
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Franklin Smith, M. D.
Oct 30, 1923 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Oct-31 1923

20 UNDERTAKER: John B Spence — ADDRESS: 1325 N. Carolina St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter on file 3-20-24)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80373

D 80373

99-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2367 N. Patterson Ave ST., 46 WARD)

2-FULL NAME John J. Edward Edgar Peirson

(a) RESIDENCE NO. 2367 N Patterson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Gertie Peirson

6 DATE OF BIRTH (month, day, and year): Dec 7 - 1877

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer): 052

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Edgar A Peirson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Madgline Lahp. Dec 24 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: Gertie Peirson (Address) 2367 N. Patterson Ave

15 Filed ..... 19 ..... Registrar

OCT 30 1923 ROBERT K. KRAMER Deputy Health Commissioner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Oct 30, 1923.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 1245 p m.

The CAUSE OF DEATH* was as follows:

- Bronchitis (Subacute)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General diagnosis

(Signed) Adolph C. Eisenberg, M. D.

(Address) 2120 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 1 1923

20 UNDERTAKER: Robt J Jones Inc

ADDRESS: 1462 W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80374

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 560 Baker ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerry Hamilton

(a) RESIDENCE NO 560 Baker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1853

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (Rubber Mfg Plant)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Maggie L. Tucker
(Address) 560 Baker St.

15 Filed ..., 192 Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute alcoholism
(Contributory unknown)

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)
Oct 27, 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2314 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80375

100-001 80375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 E. Madison St.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Jackson

(Residence in Baltimore: No. 922 E. Madison St.; ....yrs., ...mos. ....ds.)

in Balto Co. 16 mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, B

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 29, 1921.
(Month) (Day) (Year)

7-AGE, 1 yrs. 10 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Harry Jackson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Dorothy St Rose

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy St Rose

(Address) 321-21½ S Balto md

15-

Filed ....., 191....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Oct 28 1923, that I saw her alive on Oct 28 1923, and that death occurred, on the date stated above, at 1100 a.m.

The CAUSE OF DEATH* was as follows:

acute
Bronchial Pneumonia
Influenza
(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) A. L. Hartman M. D.

10/30, 1923 (Address) 733 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 31st, 1923.

20-UNDERTAKER Joseph A Farrell

ADDRESS 2317 Division St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80376

CERTIFICATE OF DEATH.

X 188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General St., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erling Engebretsen.

(a) RESIDENCE No Boston, Mass. ST., WARD Revere Mass.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10 NAME OF FATHER Hans Engebretsen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report
(Address) Southern District.

15 Filed OCT 30 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, struck and knocked down by an automobile. Accidental Death.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Oct, 29, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Accident Light & Barre Sts. 10/28/23.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co — DATE OF BURIAL Oct-31 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Denby)

D 80377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80377

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 63 W. West ST., 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Denby

(a) RESIDENCE NO. Lakeshore, Md. ST., WARD Lakeshore Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. / mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Denby

6 DATE OF BIRTH (month, day, and year): Apr. 7, 1857

7 AGE — Years: 66 — Months: 6 — Days: 20 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Pat Flannigan

9 BIRTHPLACE (city or town) (State or country): Cambridge Maryland

PARENTS

10 NAME OF FATHER: Anthony Peters

11 BIRTHPLACE OF FATHER (city ..... (State or country)

12 MAIDEN NAME OF MOTHER: Cinderella

13 BIRTHPLACE OF MOTHER (city or ..... (State or country)

14 Informant: Ella Kemp

(Address): Lakeshore, Md.

15 OCT 30 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct, 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct, 18, 1923, to Oct, 27, 1923.

that I last saw h alive on Oct, 26, 1923,

and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine Testing

(Signed) Wm Trawlen M. D.

10/29 19 23 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Oct 31 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Hicks St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80378

D 80378

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 434 E. 22nd ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wiseman

(a) RESIDENCE. NO. 434 E. 22nd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. C. Wiseman

6 DATE OF BIRTH (month, day, and year): Nov 11th 1849

7 AGE — Years: 74. Months: 11 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John A. Hollar.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Julia Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: William Wiseman
(Address) 434 E. 22nd St.

15 Filed OCT 30 1923, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th 1923, to Oct 28th 1923,

that I last saw h[illegible] alive on Oct 28th 1923,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Cause Ray Stricken

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. A. Fellner, M. D.

Oct 30, 1923 (Address) 1501 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 31 1923

20 UNDERTAKER: E. A. Wedefield — ADDRESS: 501 E. Eag[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80379

CERTIFICATE OF DEATH.

100-08 D 80379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Dorsey Lane St.: 70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Hall Frisby

(a) RESIDENCE. No. 28 Dorsey Lane St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Frisby

6 DATE OF BIRTH (month, day, and year) Nov. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. H. Hall

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md. Maryland

12 MAIDEN NAME OF MOTHER Sarah Fisher

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md. Maryland

14 Informant Mrs. Sarah Hall. (Address) 28 Dorsey Lane.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1923, to October 24, 1923, that I last saw h[illegible] alive on October 20th, 1923, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(duration) yrs. One mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Bernard Lange, M. D.

, 19 (Address) 2937 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	10-27 1923
20 UNDERTAKER	ADDRESS 916
David Carter	916 Penna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 101823

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

D 80380

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D 80380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 E. Balto. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Schmidt.

(a) RESIDENCE NO. 2917 E. Balto. ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Andrew Schmidt

6 DATE OF BIRTH (month, day, and year) Feb 12th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
81	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Shuyder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm A. Schmidt (Son)

(Address) 1642 Ellerton ave.

15 Filed Oct 30 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Oct 29 1923

that I last saw h alive on Oct 28 1923

and that death occurred, on the date stated above, at 5 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. McAvoy, M. D.

Oct 30 1923 (Address) 739 O. Ellwood av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Oct 31st 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 4033 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 30 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80381

CERTIFICATE OF DEATH.

D 80381

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 W. Lanvale ST., 16 WARD)

2-FULL NAME Nettie M. Mackessy.

(a) RESIDENCE No. 2905 W. Lanvale ST., 16 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICI... should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Mackessy.

6 DATE OF BIRTH (month, day, and year) May 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wells Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rachel Lee.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant William J. Mackessy. (Address) 21 Alton ave.

15 Filed . 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

OCT 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 , 19 , to Oct 28 , 19 ,

that I last saw h alive on Oct 28 , 19 ,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

Oct 29, 19 (Address) 1732 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Oct 31st 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 4033 Maryland

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80382

CERTIFICATE OF DEATH.

1624 D 80382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Martin

(a) RESIDENCE NO 14 Ethelbert Ave. (Pimlico) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year) Oct 23/23

AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER XXXXXXXX

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Helen Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) XXXXXX

14 Informant (Address): Johns Hopkins Hospital

15 Filed ..... 192 ..... Registrar

1 30 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Birth Hemorrhage- Intercrainal

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Collins, M. D.

(Coroner.)

Oct 26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 30 1923 192

20 UNDERTAKER

ADDRESS

Commissioner Health.

For Wm. F. Wegner.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80383

D 80383

CERTIFICATE OF DEATH.

24

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4703 Reisterstown Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfield Scott Schley

(a) RESIDENCE. No. 4703 Reisterstown Rd ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6. 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John T. Schley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Lula Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kemptown Maryland

14 Informant Mr. John T. Schley (Address) 4703 Reisterstown Rd

15 Filed . 19 Robert P. Hartlebury Registrar

CT 301923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29 . 1923 . to Oct 30 . 1923 . that I last saw him alive on Oct. 30 . 1923 . and that death occurred, on the date stated above, at 8 50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro. Spinal Meningitis (Epidemic)

about 5 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not. Known.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Beckley . M. D.

. 19 (Address) 1260 Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 31 1923
20 UNDERTAKER Jos Forsters + Son	ADDRESS 27 S. Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80384

CERTIFICATE OF DEATH.

10 D 80384

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1324 West Balto ave St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Schmeff near Hollins Ferry Road

(Residence in Baltimore: No. Wt Balt ave St.; 5 yrs., ... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, 9 (Month) 30 (Day), 1918 (Year)

7-AGE, 5 yrs. ..... mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John J Schmeff

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER ada Reine

13-BIRTHPLACE OF MOTHER (State or Country), Nova Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ada E. Schmeff

(Address) Wt Wilcox

15-

Filed ..... 191.....

Robert F. Harrison, Registrar.

CT 301923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1923, to Oct 30 1923, that I saw her alive on Oct 30 1923, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria Croup

..... (Duration) ..... yrs. ..... mos. 4 ... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Hall M. D.

10. 30, 1923 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, 11/31/23, 191...

20-UNDERTAKER Geo J Ruth — ADDRESS 1235 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80385

CERTIFICATE OF DEATH.

D 80385

1-PLACE OF DEATH

REGISTERED NO. +188-083

CITY OF BALTIMORE: (No.) University Hospital St., (Ward) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Edw Preble

(a) RESIDENCE NO. Pikesville md St., WARD Pikesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1/4 ds. How long in U. S., if of foreign birth? 20 yrs. 11 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 29 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer T. Hall

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Thos Preble

11 BIRTHPLACE OF FATHER (city or town) Maine
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Hallisey

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Thos Preble (Father)
(Address) Pikesville md

15 Filed OCT 30 1923, 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) .... yrs. 0 mos four hrs ds.

CONTRIBUTORY (Secondary) from from Automobile

(duration) .... yrs. .... mos. .... ds.

(Signed) H. K. Bond, M. D.
(Coroner.)
Oct 31, 1923 (Address) Mt Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 0 yrs., 0 mos., 1 hrs ds. In the State 21 yrs., 11 mos., 28 ds.

Where was disease contracted, if not at place of death? near Pikesville Md

Former or usual residence Pikesville Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Josephs Cemetery Texas. Md.

DATE OF BURIAL Oct 31 1923

20 UNDERTAKER STEVENS & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(See Birth Certificate attached) Also Fever

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80386

CERTIFICATE OF DEATH.

38

D 80386

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Marshall

(a) RESIDENCE NO. 511 N. Eutaw St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown 10-30-23

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

15 Filed OCT 30 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 25 19 23. to October 29 19 23, that I last saw him alive on October 29, 19 23, and that death occurred, on the date stated above, at 5:35 P. M.

The CAUSE OF DEATH* was as follows:

Syphilis

C. N. S. Syphilis

Unknown

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude A. Jones M. D.

19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass.

DATE OF BURIAL Oct 30 1923

20 UNDERTAKER Wm. Miles & S. Pink.

ADDRESS 1737 N. Pratt St

OCT 30 1923

Information, which should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

Dr. C.Hampson Jones.

November 22, 1923.

This is to certify that Edward Marshall (white) a Everett was admitted to Bay View Hospital October 25, 1923 in a stuporous condition and was unable to give his age or an accurate history. He died October 29, 1923, the final diagnosis being syphilis and cerebro-spinal syphilis (general paresis).

Claude G. Drace

Claude G. Drace, M.D.
Resident Physician.

Commonwealth of Massachusetts

City Clerk's Office, Quincy, Nov. 12 1923

I, Marguerite S. Lyons hereby certify that I hold the office of City Clerk, and have the custody of the Records of this City relating to BIRTHS, and that the following is a copy from the Records of Births in said City:-

Date of Birth Dec. 7, 1896

Name of Child Everett Marshall

Sex male

Place of Birth Quincy

Residence of Parents 19 Liberty St. Quincy

Name of Father William

Occupation of Father Stone-cutter

Birthplace of Father Scotland

Maiden Name of Mother Maggie Wood

Birthplace of Mother Scotland

IN WITNESS WHEREOF I hereunto set my hand and the seal of said City, this day and year first above written.

Marguerite S. Lyons
asst City Clerk.

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

November 24,1923.

Dr. C. Hampson Jones.
City Health Department.
Baltimore, Md.

My dear Dr. Jones,

Will you please change the age of Edward or Everett Marshall, who, died in this hospital October 29,1923 from 40 ? to 28, and the duration of disease syphilis & C.N.S syphilis from 20 yrs to unknown duration.

Thanking you very kindly, I am

Yours truly,

Claude G Dunn

Resident Physician.

CGD/MAH.

Spec.—1-10-21—M&T—1500 Blks.

D 80387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80387

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 25 WARD)

2-FULL NAME Anthony Blasarius or Blasunis

(a) RESIDENCE NO. 430 Filbert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	unknown ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuanian

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuanian

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Municipal Hospital Records.

(Address)

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

CT 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from October 25, 1923, to October 27, 1923, that I last saw h in alive on October 26, 1923, and that death occurred, on the date stated above, at 6:35 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) yrs. 2 mos. (History)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Dehaven, M. D.

10-28 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patrick's Cemetery

DATE OF BURIAL 10/31 1923

20 UNDERTAKER Mrs M Funk

ADDRESS 1737 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80388

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Twamley

(a) RESIDENCE No. Bay View Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Troy, New York

PARENTS

10 NAME OF FATHER Isaac Twamley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Municipal Hospital Records. (Address)

15 Filed , 19 Registrar

OCT 30 1923

Robert F. Martinon, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 14, 19 21, to October 30, 19 23

that I last saw him alive on October 29, 19 23,

and that death occurred, on the date stated above, at 8:00 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis

C.N.S Syphilis (Tabo-Paresis)

Residual Hemiplegia (Syphilitic)

(duration) 25 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude S. Dreas, M. D.

10-30-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 1 1923

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

18 83389 D 80389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor. Lombard & Green ST. S. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar L. Guyton

(a) RESIDENCE NO. New Windsor, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Cora Guyton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher 068

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Wm L. Guyton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Beachley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed OCT 31 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1923, to Oct 30, 1923, that I last saw h.. alive on Oct 30, 1923; and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Post Operative).

Probably typhoid ? ?

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer ?

Chronic appendicitis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct 27-23

Was there an autopsy? yes

What test confirmed diagnosis? Clinical test.

(Signed) Mark D Lynn, M. D.

, 19 (Address) 41 W Preston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Windsor Md — DATE OF BURIAL Nov 1st 1923

20 UNDERTAKER J H Bankard & Son — ADDRESS Westminster Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80390

CERTIFICATE OF DEATH.

108 D 80390

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 E. Madison ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Helm

(Residence in Baltimore: No. 922 E. Madison St St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... October (Month) 8 (Day) 1922 (Year)

7-AGE, ... yrs. 11 mos. 20 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Willie Helm

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Josephine White

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine White

(Address) 922 E Madison St

15-

Filed OCT 31 1923, 191.... ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1923, to Oct 27 1923, that I saw him alive on Oct 27 1923, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Ulceration Stomach

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. H. Bonnette M. D.

10/30, 1923 (Address) 733 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov 3, 1923
20-UNDERTAKER	**ADDRESS**
Mrs Robert J Elliott	Oakland Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80391

CERTIFICATE OF DEATH.

65-001 D 80391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Dallas ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Gaskins

(a) RESIDENCE NO. 822 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur E. Gaskins

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Rosa Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Rosa Miller

(Address): 822 N. Dallas St

15 Filed OCT 31 1923 ROBERT F. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923 to Oct. 29, 1923.

that I last saw her alive on Oct. 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Malarial fever & Mitral reg. (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

10/31 1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Cemetery — DATE OF BURIAL: Nov 1923

20 UNDERTAKER: Wm. Robt. A. Elliott — ADDRESS: 725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Bks.

D 80392

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 80392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2509 Foster Ave., E., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Loeffler

(a) Residence No. 2509 Foster Ave E., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Loeffler

6-DATE OF BIRTH (month, day and year) Aug. 16-1857

7-AGE. 66 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Johannas Loeffler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Anna Loeffler

(Address) 2509 Foster Ave

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7 19 23 to Oct. 28 19 23

that I last saw h— alive on Oct 28 19 23

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac - Valvular -

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) M. D.

. 19 (Address) 125 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	Oct. 31, 1923
20-UNDERTAKER.	**ADDRESS**
H. Gainder & Sons	1710 Fleet St.

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 80393

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N. Eden ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Fladung.

(a) RESIDENCE NO. 1008 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? 61 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Matilda Fladung.

6 DATE OF BIRTH (month, day, and year) Dec. 7. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 017

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Bernard Fladung

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Matilda Fladung

(Address) 1008 N Eden St

15 Filed OCT 31 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1923 to Oct 29 1923.

that I last saw h living on Oct 29 1923,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Senile Debility.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Emil E Kellerman M. D.

Oct 31, 1923 (Address) 928 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL Nov 2nd 1923

20 UNDERTAKER: Henry Hoeck Son ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80394

CERTIFICATE OF DEATH.

129 D 80394

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatz Laure

(a) RESIDENCE NO. 2203 Lynnhurst Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernestine Laure

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mgr 080

(b) General nature of industry, business, or establishment in which employed (or employer) Furst Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Jack Lewis (Address) 1439 Eastern Ave

15 Filed OCT 31 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to Oct 30, 1923,

that I last saw h im alive on Oct 30, 1923,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

— Arteriosclerotic Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Isidore D. Fry M. D.

10/30, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL 10/31 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80395

CERTIFICATE OF DEATH.

90 D 80395

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 W Lafayette Ave WARD 16)

2-FULL NAME Helen M. Watkins

(a) RESIDENCE NO 1717 W Lafayette Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthews Watkins

6 DATE OF BIRTH (month, day, and year) Oct 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Orlando G White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Sarah Klassen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Wm G White
(Address) 2108 St Paul St.

15 Filed OCT 31 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(Duration) 1 yrs. mos. ds.

(Signed) Geo Clinton Bates M. D.
(Coroner)

Oct 31 1923 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Pa	Oct 31 1923
20 UNDERTAKER John O. Mitchell	ADDRESS 1300 Fayette

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 ✓ D 80396

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Ivy Alley. ST., 4 WARD)

2-FULL NAME Hom You

(a) RESIDENCE NO. 211 Ivy alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Chinese	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hom, Toy To

6 DATE OF BIRTH (month, day, and year) August 5, 1875

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
	49	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ---------- 045

(c) Name of employer ----------

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Hea Fong ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Hom Gong, (Address) Annapolis, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29, '23

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to Oct. 28. 1923. that I last saw him alive on Oct 28. 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Over (duration) 2 yrs. 7 mos. ✓ ds.

CONTRIBUTORY (Secondary) None (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Dable, M. D.

Oct 30 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 11/1/23 19

20 UNDERTAKER: JOHN O. MITCHELL, 1201W. Fayette — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80397

HEALTH DEPARTMENT—CITY OF BALTIMORE D 80397

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Andrea St ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Steinitz

(a) RESIDENCE NO. 1333 Andrea St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Steinitz

6 DATE OF BIRTH (month, day, and year) 9/23/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	I	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER George Reichle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Oscar Steinitz

(Address) 1333 Andrea St

15 Filed OCT 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Oct. 29, 1923, that I last saw h alive on Oct. 11, 1923, and that death occurred, on the date stated above, at 8a ; M. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

(duration) 2 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Gastritis yrs. mos. 1 ds.

(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Kurz M. D.

10-30, 1923 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Oct 31 1923

20 UNDERTAKER John Keerins ADDRESS 1008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80398

D 80398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 17 N POtomac ST., 6 WARD)

2-FULL NAME Philip Reinemer

(a) RESIDENCE NO. 17 N Potomac St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thersa Reinemer

6 DATE OF BIRTH (month, day, and year) May--1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 909
(c) Name of employer Canning Industry

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip Reinemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Reinemer
(Address) 17 N .Potomac St.

15 Filed OCT 31 1923 ROBERT F. KRAUTER, Burial Permit Clerk Registrar

TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chronic Myocaditis

(duration) yrs. mos ds.

CONTRIBUTORY (History of bad heart)
(Secondary)

(duration) yrs. mos. ds.

(Signed) S. S. Rollins (Coroner), M. D.

Oct 30/23 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Oct 31 192 3
20 UNDERTAKER John A Morau	ADDRESS 3000 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80399

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1818 Belt St. ST.: 24 WARD)

2-FULL NAME Christine Harris.

(a) RESIDENCE. No. 1818 Belt St. ST., 24 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mns. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Harris.

6 DATE OF BIRTH (month, day, and year) July, 5, 1898.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25,	3,	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Alfred Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Cook.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: William H. Harris.
(Address): 1042 William St.

15 Filed OCT 31 1923 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 , 1923 , to Oct 29 , 1923 , that I last saw h~~e~~r alive on Oct 29 , 1923 , and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) continuous yrs. mos. ds.

CONTRIBUTORY (Secondary) contributory

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) H. L. Smith M. D.

. 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov. 1, 1923
20 UNDERTAKER	ADDRESS
Harold Howard Evans	1428 S. Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80400 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80400

CERTIFICATE OF DEATH.

187-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME John Cook

(a) RESIDENCE NO. 406 Lemon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work General Elevator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Frank J Sons & Co

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Danny Johnson
(Address)

15 Filed OCT 31 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal injuries

(duration) 4 Min hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Fall in Elevator Shaft

(duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

10-31, 192 (Address) 1131 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Oct. 31 1923

20 UNDERTAKER Saml Ensley — ADDRESS N. Bdle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80401

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 627 Hackesley Place ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph le Holmes

(a) RESIDENCE NO. 1627 Hackesley Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	0	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma E Kurz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Joseph Holmes

(Address) 627 Hackesley Place

15 Filed OCT 31 1923 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-24 1923 to 10-30 1923,

that I last saw h alive on 10-29 1923

and that death occurred, on the date stated above, at 1-30 a m.

The CAUSE OF DEATH* was as follows: Cholera Infantum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Gastro-enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A J Bruce M D, M. D.

10/30 1923 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 1 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E 40th

N. B.—Every question should be carefully answered. If unknown, "unknown" should be stated. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor. ~~Cert.~~ MAT 100 Bks.

D 80402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80402

CERTIFICATE OF DEATH.

5 74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 105 N. Front ST., 5 WARD)

2-FULL NAME William Johnson

(a) RESIDENCE No 105 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Johnson

6 DATE OF BIRTH (month, day, and year) Oct 6, 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	—	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Sadie Johnson
(Address) 105 N. Front St

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Carbon Monoxide Gas

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)

Oct 30, 1923 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mrs Cathedral	Oct 31 1923

20 UNDERTAKER Wm. Cook ADDRESS 507 E. Fayette St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80403

CERTIFICATE OF DEATH.

90 D 80403

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Fremont ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merritt Jameson

(a) RESIDENCE NO. 811 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Lina Jameson

6 DATE OF BIRTH (month, day, and year) Apr 20 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	6	10	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) for Oyster House

(c) Name of employer Killian & Co

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER John Jameson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Susan Merritt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Lina Jameson (Address) 811 N Fremont

15 Filed OCT 31 1923 ROBERT R. KRAETER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923, to Oct 30, 1923, that I last saw him alive on Oct 29, 1923, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows: Valvular disease of heart

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William E Burton, M. D.

(Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL Nov 1st 1923

20 UNDERTAKER A. M. Walker

ADDRESS 23 N Lafayette Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80404

CERTIFICATE OF DEATH.

74-001 ✓

D 80404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Emmel Ave. ST., Hamilton 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Thomas

(a) RESIDENCE NO. 208 Emmel Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year) Jan. 20 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	79	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Samuel West

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Henry O'Donnell (Address) 208 Emmel Ave.

15 Filed OCT 31 1923 HUBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Oct 30, 1923.

that I last saw h alive on Oct 27, 1923,

and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

10/31 19 23 (Address) 4206 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Balto

DATE OF BURIAL 11/1 1923

20 UNDERTAKER J. Frank [illegible]

ADDRESS 130 E. Fay

Spec.—1-10-21—M&T—1500 Bks.

D 80405 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80405

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 934 Rutland Ave ST., 7 WARD)

2-FULL NAME Milton Butler

(a) RESIDENCE NO. 934 Rutland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Albert Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Charles County Md

12 MAIDEN NAME OF MOTHER Carrie Buster

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Carrie Butler
(Address) 934 Rutland Ave

15 Filed , 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1923

17

I HEREBY CERTIFY, That I attended deceased from August 28. 1923. to October 27. 1923.
that I last saw him alive on October 27. 1923.
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

External Haemorrhage of Abdomen

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Internal Injury of abdomen

(duration) yrs. 6 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. H. Mennard, M. D.

10-30 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Oct 30 1923

20 UNDERTAKER Harr R A Elliott — ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Rosa Scott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80406

CERTIFICATE OF DEATH.

90 D 80406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Latrobe St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Scott

(a) RESIDENCE NO. 1706 Latrobe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ed. Scott

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Servant
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer
(c) Name of employer: Own

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Parker
(Address): 1707 Latrobe

15 Filed ....., 192 .....
Registrar

OCT 31 1923 HOWARD H. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 - 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis. heart

Duration Rheum — Acid endocard (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Miller, M. D. (Coroner.)

Oct 31, 192 3 (Address) 1699 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Nov 1 192 3

20 UNDERTAKER: Mrs Robert F Elliott — ADDRESS: 1721 Arlington Ave

D 80407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 80407

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Christian Dietz

(Residence in Baltimore: No. 3117 Wilkens Ave. St.; yrs. 30 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	M

6-DATE OF BIRTH. October 3rd. 1893
(Month) (Day) (Year)

7-AGE. 30 yrs. mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Corkran Hill Co.

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Dietz

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Kate Lindauer

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary L. Dietz

(Address) 3117 Wilkens Ave.

15-

Filed OCT 31 1923 By ROBERT R. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 28 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoning Hydrocyanic Acid
Suicide

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) H. C. Davis M. D.
(Coroner.)

Oct 30th 1923 (Address) 143 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Oct 31st 1923

20-UNDERTAKER. Joseph B Cook

ADDRESS 1003 N. Bal. St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80408 D 80408

CERTIFICATE OF DEATH.

REGISTERED NO. 132

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2 Belvidere Terrace ST., 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Power DeHoff

(a) RESIDENCE NO. 2 Belvidere Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Gonce

6 DATE OF BIRTH (month, day, and year): April 28, 1873

7 AGE — Years: 50 — Months: 6 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Secretary and Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Carville Benson

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John H. De Hoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Sophia Crumblitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Jesse B. De Hoff

(Address): 3 Bayonne Ave. Hamilton, Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/29/23

17 I HEREBY CERTIFY that I attended deceased from Aug 1st, 1923 to Oct 29, 1923 that I last saw him alive on Oct 28, 1923 and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows: Chronic Bright's Disease

(duration) 3 Years

CONTRIBUTORY (Secondary): Renal Stone (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry F. Cassidy M. D.

10/29 1923 (Address) Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. — DATE OF BURIAL: Oct 31 1923

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 80409

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin & Hospital ST., 25 WARD)

2-FULL NAME John L Stanning

(a) RESIDENCE NO. 532 Annapolis ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. (Brooklyn) mos. ds. How long in U. S., If of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clementine Stanning

6 DATE OF BIRTH (month, day, and year): Oct 14 1865

7 AGE — Years: 58 Months: 8 Days: 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Plymouth England

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Ida C Stanfield

(Address) 532 Annapolis Ave

15 Filed OCT 31 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct-12-, 1923, to Oct-28-, 1923, that I last saw him alive on Oct 28, 1923 and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

Omentum & Intestines

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. J. Parr, M. D.

, 19 (Address) Bon Sec Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Nov 1st 1923

20 UNDERTAKER: Joseph. B. Cook — ADDRESS: 1003 N Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80410

CERTIFICATE OF DEATH.

1-001 ✓ D 80410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hosp (ST.) (WARD) W

2-FULL NAME Rose Glasser.

(a) RESIDENCE NO. 1508 Ashland (ST.) Av (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kuhn

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm Glasser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Pipman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Esther Glasser (Address) 1508 Ashland ave

15 Filed OCT 31 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1923, to Oct 31. 1923.

that I last saw her alive on Oct 31 1923

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis ferd.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? No. Date of 8/23/23.

Was there an autopsy? No.

What test confirmed diagnosis? Widal +.

(Signed) J. Schmunk M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 10/31 1923

20 UNDERTAKER H. Lurie & Bro

ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 80411

CERTIFICATE OF DEATH.

D 80411

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 S Collington Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Donoho

(a) RESIDENCE. No. 233 S Collington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Carrie L Donoho

6 DATE OF BIRTH (month, day, and year) 10/27/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain of Barge

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wicomico County Md

PARENTS

10 NAME OF FATHER Wm Donoho

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wicomico Co Md.

12 MAIDEN NAME OF MOTHER Sallie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wicomico Co Md

14 Informant Mrs Roberts (Address) 233 S. Collington Ave

15 Filed OCT 31 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1923, to Oct. 31st, 1923, that I last saw him alive on Oct 30th, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chas. A Neer, M. D.

10/31/1923 (Address) 408 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mardella Springs Md.

DATE OF BURIAL 11/1 1923

20 UNDERTAKER Albert L. Hilty Jr

ADDRESS 1606 1606 h Chester St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 80412 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 80412

1-PLACE OF DEATH — Registered No. 16 90

City of BALTIMORE: (No. 900 N. Fulton Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin M. Jory

(a) Residence No. 900 N. Fulton Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~ ~~Married~~ Widowed, ~~or Divorced~~, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Jory

6-DATE OF BIRTH (month, day and year) Nov 21st, 1843

7-AGE,			If LESS than 1 day,
79 yrs.	11 mos.	9 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Sign Co. 045

(c) Name of employer Self

9-BIRTHPLACE (city or town) Bridgeton N. J. (State or Country),

PARENTS.

10-NAME OF FATHER, Benjamin Jory

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth T. Godfrey

13-BIRTHPLACE OF MOTHER (city or town) .. New Jersey (State or Country).

11- (Informant) Edgar E. Jory

(Address) 900 N. Fulton Ave

15- Filed OCT 31 1923 ROBERT P. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 30th, 1923

17- I HEREBY CERTIFY, That I attended deceased from 1-1- 1923 to 10/30 1923

that I last saw ~~him~~ alive on 10/28 1923

and that death occurred, on the date stated above, at 8 A. m.

The ~~CAUSE OF~~ DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Emil Engert M. D.

10/31, 1923 (Address) 1978 N Dallas Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cemetery	Nov. 1st, 1923

20-UNDERTAKER. Putnam Bros. ADDRESS 1123 W. Lex. St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80413

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 503 S Chester St. 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Summerfield

(a) Residence No. 503 S Chester St., 1st Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Aug 19 / 23

7-AGE: — yrs. 2 mos. 12 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Jos J. Summerfield

11-BIRTHPLACE OF FATHER (city or town) (State or Country): City

12-MAIDEN NAME OF MOTHER: Eva Lanneman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): City

14- (Informant) Mr J. Summerfield

(Address) 503 S Chester St

15- Filed OCT 31 1923 ROBERT R. KRAUSE, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 31-23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1923 to Oct. 31 1923

that I last saw h— alive on Oct 30 1923

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion —

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Not

What test confirmed diagnosis? Visual

(Signed) Dr. A. Bruer, M. D.

, 19 (Address) 1252 Bty

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer H.C.C. DATE OF BURIAL, Nov 1st, 19 23

20-UNDERTAKER, Peter Nicolaus ADDRESS 2010 Eastern Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80414

101-001 ✓

CERTIFICATE OF DEATH.

D 80414

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Ward ST., 21 WARD)

2-FULL NAME Leopold Greenbaum

(a) RESIDENCE NO. 1404 Ward. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 10, 1864

7 AGE — Years: 60 Months: 6 Days: 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder's 45

(b) General nature of industry, business, or establishment in which employed (or employer): Supplies

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Solomon Greenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Adler (Address): New York

15 Filed OCT 31 1923, 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/30/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1923, to Oct. 30, 1923.

that I last saw h/ alive on Oct 29, 1923,

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Whitridge Williams M. D.

Oct 30 1923 (Address) 719 Mark Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL: 11/1/ 1923.

20 UNDERTAKER: Dard Sondheim ADDRESS: 118-20 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80415

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1710 Thames ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Miles

(a) RESIDENCE NO 1710 Thames ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 40		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) Ofb
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dept
(Address) Eastern Dist

15 Filed OCT 31 1923, 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
or over

(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jno. B. Horton M. D.
(Coroner)

Oct 30 192 3 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

Disinterred and Interred in St. Patricks Cem

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC[illegible]
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80416

179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Columbia Ave ST., 12th WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin L. Wright

(a) RESIDENCE NO. 826 Columbia ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sept. 13 —, 1874.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	1.	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William H Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Lorenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Emma J. Stumpf

(Address) 826 Columbia Ave

15 Dec 31 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 23, to Oct 30, 19 23,

that I last saw him alive on Oct 30, 19 23

and that death occurred, on the date stated above, at 7 35 m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Howard, M. D.

Oct 31, 19 (Address) 739 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hazelton Md — DATE OF BURIAL Nov 1 1923

20 UNDERTAKER Josiah Syfer — ADDRESS 1603 N. North ave

OCT 31 1923

Robert F. Harrison,

Burial Permit Clerk.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 80417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 80417

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., 3 Ward) Municipal Tuberculosis Hospital

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carr

(a) Residence No. 1007 Salisbury Alley St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1887

7-AGE.	If LESS than 1 day,
36 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: .....

9-BIRTHPLACE (city or town): Baltimore
(State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Allen Carr

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country): South Carolina

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country): Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed, 19.. Robert P. [illegible] 0828 Registrar.

3-31-1923 Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 10 19 23 to Oct. 28 19 23

that I last saw him alive on Oct. 28 19 23

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum, X-ray

(Signed) [signature] M. D

10-29, 1923 (Address) Municipal Tbc. Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL ..... 19....
20-UNDERTAKER, Commissioner Health.	ADDRESS

HOPKINS HOSPITAL

Should be carefully Applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D 80418

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Johnson.

(Residence in Baltimore: No. 909 Penna Ave St.; yrs. 28 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored.	Married

6-DATE OF BIRTH. 1878
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
45 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Jno Galloway.

11-BIRTHPLACE OF FATHER. (State or Country) Md.

12-MAIDEN NAME OF MOTHER. Lucy Brown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. H. Baker

(Address) 92 W. Chase

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

T 21 1923 Burial Permit Cle

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 29 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis respiratory Center
due to Ether anesthesia
while removing fibroid uterus
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) 7 minutes
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Oct 31 192. (Address) 16 W. Lex

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
South River Ann	11—3—1923

20-UNDERTAKER.	ADDRESS
Daniel Eyler	16 Penna ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 80419

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 80419

31

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 830½ Lemon ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Robinson

(Residence in Baltimore: No. 836½ Lemon St.; 40 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE C

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) M

6-DATE OF BIRTH July (Month) 5 (Day), 1882 (Year)

7-AGE 41 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Robinson

(Address) 830½ Lemon St

15

Filed OCT 31 1923, 191

Robert P. Harrison
REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct (Month) 29 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I saw h... alive on ....., 191...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-2-, 1923

20-UNDERTAKER Dud Eckard

ADDRESS 910 Jamaica

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80420

CERTIFICATE OF DEATH.

10-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 550 St. Mary St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Richard Burgess

(a) Residence No..... 550 St. Mary St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Jane Burgess

6-DATE OF BIRTH (month, day and year) Aug 16 1864

7-AGE, 59 yrs. — mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Porter

(b) General nature of industry, business, or establishment in which employed (or employer)..... — 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Richard Burgess

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Christ Briggs

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country),

11- (Informant)..... David Easton

(Address)..... 916 Penna Ave

15- Filed..... 192 .....
Registrar.

T 3 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-30-1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Oct 30, 1923, that I last saw him alive on Oct 30, 1923, and that death occurred, on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Dana E. Tolliver M. D.

Oct 31, 1923 (Address) 1706 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Nov 2 1923

20-UNDERTAKER, David Easton

ADDRESS 916 Penna Ave

Under penalty of law, this certificate must be filled in typewriting or with pen and ink, and no certificate will be accepted for registration which has been altered in any way after it has been signed. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80421

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

D 80421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Brewer

(a) RESIDENCE NO. 1621 Jackson St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Boy

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14 1923

7 AGE — Years: — Months: — Days: 16 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ditto

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Leroy Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ella Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) C C Brewer 1621 Jacksonst

15 Filed NOV 1 - 1923, 19 .... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923, to Oct 30, 1923; that I last saw him alive on Oct 30, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - convulsions - respiratory paralysis - (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? none.

What test confirmed diagnosis? .....

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 11/1/1923

20 UNDERTAKER: J. J. Bailey & Sons. — ADDRESS: 1318 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Instrumental Delivery
Injury

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80422

CERTIFICATE OF DEATH.

66 ✓ D 80422

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 616 N. Stockton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. Garrison

(Residence in Baltimore: No. 616 N. Stockton St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 29, 1883 (Month) (Day) (Year)

7-AGE, 40 yrs. 7 mos. 0 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hotel Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, Samuel R. Garrison

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Katie ——

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel H. Garrison

(Address) 616 N. Stockton

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1923, to Oct. 29 - 1923, that I saw h[illegible] alive on Oct. 29 - 1923, and that death occurred, on the date stated above, at 7:10 p. m.

The CAUSE OF DEATH* was as follows: Acute dilatation

Benign Ventricular dilatation.

..... (Duration) ..... yrs. ..... mos. One ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Coleman M. D.

Oct 30, 1923 (Address) 713 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem

DATE OF BURIAL, Nov. 1, 1923

20-UNDERTAKER David Easton

ADDRESS 916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 1 - 1923 ROBERT P. KRAUTER

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80423

CERTIFICATE OF DEATH.

90 D 80423

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Patapsco St. ST. 23 WARD)

2-FULL NAME Mary E. Creamer.

(a) RESIDENCE NO 1728 Patapsco St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced
(or) WIFE of John F. Creamer.

6 DATE OF BIRTH (month, day, and year) January 28, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ------- Rutter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co, Md.

12 MAIDEN NAME OF MOTHER Mary Wilson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co, Md.

14 Informant Gertrude Wirth. (daughter)
(Address) 1413 Washington Blvd.

15 Filed NOV 1 - 1923 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and kidneys.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Oct, 31, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov. 2nd 1923.

20 UNDERTAKER Mrs Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80424

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/4 D 80424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 12 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James K. Brice

(a) Residence No. 420 W. 25th st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

8-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): July 7 1881

7-AGE: 42 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Geo. W. Brice

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Margaret Bellison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

11- (Informant): Hospital Records

(Address): M.T.H.

15- Filed, 192 ROBERT R. KRAUER Registrar.

NOV 1 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19 1923 to Oct. 31 1923

that I last saw him alive on Oct. 31 1923

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally M. D

10-31, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden

DATE OF BURIAL: Nov 3 1923

20-UNDERTAKER: Chenoweth & Son

ADDRESS 36 S Chestnut Ave

SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80425

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 - D 80425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 850 Washington St. Ward 31)

2-FULL NAME Grace Wilcox

(a) RESIDENCE. No 850 Washington St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John R Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ruby Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John R Miller

(Address) 850 Washington St

15 Filed ..... , 19 ..... Registrar

NOV 1 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/20/ 1923, to 10/31/ 1923, that I last saw her alive on 10/31/ 1923, and that death occurred, on the date stated above, at 7:35 m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 1 ds. 1

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Braun, M. D.

, 19 (Address) 1109 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 2 19 23

20 UNDERTAKER John J Fields ADDRESS 1705 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80426

CERTIFICATE OF DEATH.

11-001 D 80426

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1738 N. Pulaski Street St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca Bogard

(a) Residence No. 1738 N. Pulaski St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Bogard

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore Street

15- Filed NOV 1 - 1923 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/31/23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8th, 1923 to Oct. 31, 1923

that I last saw h[illegible] alive on Oct. 31, 1923

and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Benjamin Tirshwell M. D.

Nov 1, 1923 (Address) 1804 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Mt. Kenseico Cem

DATE OF BURIAL. 11/1/23

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 E Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80427

CERTIFICATE OF DEATH.

3 MD 80427

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument ST., 4 WARD)

2-FULL NAME Mr. Samuel Isaacson

(a) RESIDENCE NO. 704 N. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Yetta Isaacson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 27 Months — Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Kopel Isaacson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St

15 Filed , 19 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1923, to Oct 31, 1923, that I last saw h[illegible] alive on Oct 31, 1923, and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs mos 19 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 1 yrs. 10 mos.? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidor I. Fry M. D.

1923 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 11/1 1923

20 UNDERTAKER Jack Lewis 1439 E. Baltimore St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80428

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 188-003

D 80428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Anatol Czarnecki

(a) RESIDENCE NO. 119 G St N.W. Washington D C ST., WARD Washington DC
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred few minutes ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Meter Reader
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer —

9 BIRTHPLACE (city or town) N J
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) ( )
(State or country) ( )

12 MAIDEN NAME OF MOTHER ( )

13 BIRTHPLACE OF MOTHER (city or town) ( )
(State or country)

14 Informant Veronica Czarnecki
(Address) 119 G St N.W. Washington D C

15 Filed ....., 192 .....

NOV 1 - 1923

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)
thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull & internal injuries a few hours
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Knocked from Automobile
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Bowles, M. D.
(Coroner.)

11-1-, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Nov 1 1923

20 UNDERTAKER Harry N. Witzke ADDRESS 1521 W. Lombard St

ROBERT N. KRAUT
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80429

D 80429

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 133 W. Henrietta ST., 23 WARD)

2-FULL NAME George Barnes

(a) RESIDENCE No. 133 W. Henrietta ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Morphogenous (no 202)

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edith Barnes

(Address): 133 W. Henrietta St.

15 Filed NOV 1 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/15/1923 to 10/30/1923.

that I last saw h[illegible] alive on 10/29/1923.

and that death occurred, on the date stated above at 3.25 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Kenneth Mason, M. D.

10/31/1923 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov 2 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS: 142 N. Howard St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 80430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 340 Canal ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Waters

(a) RESIDENCE. NO. 340 Canal ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Waters

6 DATE OF BIRTH (month, day, and year) Sept 27-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jno. Hazenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hazenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Louis Grimm

(Address) 340 Canal St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Oct. 29, 1923, that I last saw her alive on Oct. 29, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) 1 yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	nov 2 1923
20 UNDERTAKER	ADDRESS
John H. Todd Sons	142 Uhler St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80431

D 80431

CERTIFICATE OF DEATH.

57

D 80431

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 W. Lee ST. 22 WARD)

2-FULL NAME Charles Henry Blauvelt

(a) RESIDENCE NO. 527 W. Lee ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine R. Blauvelt

6 DATE OF BIRTH (month, day, and year): Feb 16 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	66	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager of Warehouse

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Wm. J. Pickerstons

9 BIRTHPLACE (city or town) (State or country): New York New York

PARENTS

10 NAME OF FATHER: James Blauvelt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Katherine R. Blauvelt 527 W Lee St

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Oct 31 1923,

that I last saw him alive on Oct 30 1923,

and that death occurred, on the date stated above, at 6.05 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes + Nephritis (chronic)

about 2 yrs. 9 mos ..... ds. (duration)

CONTRIBUTORY (Secondary): Coma

(duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Krauter, M. D.

11/1, 1923 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Nov 2 1923

UNDERTAKER: Wm J Pickerstons

ADDRESS: Balto Md

Spec.—1-10-21—M&T—1500 Bks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80432

X 49

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

2-FULL NAME Mr William Taylor Milton,

(a) RESIDENCE NO. 1402 Park, Ave, ST., ... WARD ..... Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife dead. Hannie D Milton

6 DATE OF BIRTH (month, day, and year): July 17. 1838

7 AGE — Years: 85 — Months: 3 — Days: 14 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Alexander Ross Milton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Harriette McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hospital Records

(Address): 33-7 E Calvert St

15 Filed ....., 19 ..... Registrar

ROBERT E. KRAUTER, Health Commissioner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1923, to Oct 31, 1923,

that I last saw him alive on Oct 31, 1923,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate (with Urinary obstruction + Uremia)

(duration) 0 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Obstruction to passage of Urine + Uremia (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) OB Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berryville Va — DATE OF BURIAL: Nov 1 1923

20 UNDERTAKER: Wm J Pickrell Sons — ADDRESS: Norfolk Va

Spec.—[illegible]-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80433

D 80433

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1404 E Fairmount Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stewart.

(a) RESIDENCE. No. 1404 E. Fairmount Ave., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 39 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Gen

(c) Name of employer

9 BIRTHPLACE (city or town) Jamaica
(State or country) British West Indies

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Jamaica
(State or country) B W I

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Jamaica
(State or country) B W I

14 Informant Jennie McGlocken
(Address) 1404 E Fairmount Ave

15 Filed NOV 1 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Oct 30, 1923, that I last saw h[illegible] alive on Oct 30, 1923, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

2 days 9 days

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? e

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? e

(Signed) J. Edward Fisher, M. D.

Oct 31 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: Nov. 2 23

20 UNDERTAKER: Chas. N. Johnson

ADDRESS: 416 N. Carey

Hall

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Atkins

(a) RESIDENCE NO. 1609 Eutaw PL ST., WARD Georgia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: 34 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: O. B. Jett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga.

12 MAIDEN NAME OF MOTHER: Josephine [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga.

14 Informant: Johns Hopkins Hosp

(Address)

15 Filed NOV 1 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Oct 31, 1923, that I last saw her alive on Oct 31, 1923, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Georgia Sept 6-1923

Did an operation precede death? Yes Date of Oct 30-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Path exam

(Signed) Warfield M Theobald, M. D.

(Address) 710 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ATLANTA GA. DATE OF BURIAL: 11/1/23

20 UNDERTAKER: H E Wyckoff & Co ADDRESS: Atlanta Ga

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Malignant

Spec.—1-10-21—M&T—1500 Bks.

D 80435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80435

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hospital for the Women of Maryland

CITY OF BALTIMORE: (NO. 1 Lafayette Ave ST. John ST., 14 WARD)

2-FULL NAME Mrs. Elizabeth Herpy

(a) RESIDENCE NO. Ashtabula Ohio. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of John Herpy

6 DATE OF BIRTH (month, day, and year) Sept 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ylistaro, Finland

PARENTS

10 NAME OF FATHER ~~Eon~~ Jacob Ulvinen

11 BIRTHPLACE OF FATHER (city or town) Ylistaro (State or country) Finland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Ylistaro (State or country) Finland

14 Informant Mrs. W. R. Black (daughter)
(Address) 5107 Pennsylvania Ave, Baltimore, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-23 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to Oct. 31st, 1923.

that I last saw her alive on October 31st, 1923.

and that death occurred, on the date stated above, at 5-57 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas with secondary involvement of liver

(duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia—pleurisy with effusion (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Physical exam + X-ray

(Signed) A. Ogle Warfield, Jr. M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ASHTABULA, OHIO

DATE OF BURIAL: 11/1/23 19

20 UNDERTAKER: H. E. Hughes

ADDRESS: 424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80436

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1219 W. Balto. ST., 18 WARD)

2-FULL NAME Fanny Wachtel

(a) RESIDENCE No. 1219 W. Balto. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Wachtel

6 DATE OF BIRTH (month, day, and year): Oct. 3, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Jacob Wachtel 1219 W. Balto. St.

15 Filed ..., 19... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/31/1923.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Oct 31, 1923, that I last saw her alive on Oct. 31, 1923, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - (hypertension)

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary): edema of lungs

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leitz, M. D.

10/31, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 11/ /1923.

20 UNDERTAKER: David Sondheim

ADDRESS: 18-20 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80437

CERTIFICATE OF DEATH.

44 D 80437

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nickens

(a) Residence No. 608 Madeira st. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1887

7-AGE: 36 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: John Nickens

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Ada Barkley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed NOV 1 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 24 1923, to Oct. 30 1923, that I last saw him alive on Oct. 30 1923, and that death occurred, on the date stated above, at 9.15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) L. C. Lallye, M. D.

10-30-23 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Bonnie Cemetery	Nov. 2, 1923.
20-UNDERTAKER.	ADDRESS
Edward Bryon	1631 Orleans st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80438 ✓ X 162 D 80438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. North Broadway ST., 6 WARD)

2-FULL NAME Baby Stachowski.

(a) RESIDENCE NO. New Pittsburg. Colgate. Baltimore County. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 29-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 00

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael F. Stachowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva Szymanski.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Father, Michael F Stachowski
(Address) — Colgate Baltimore

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1923 to Oct 31, 1923.
that I last saw h live on Oct 31, 1923.
and that death occurred, on the date stated above, at 7:05 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease
of the new born

— (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Prematurity - 8 months
(Placenta Praevia) (Duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cayetano Paulucci, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	11/1- 1923.
20 UNDERTAKER	ADDRESS
M F. Sadowski.	705 S. Ann St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 1 1923 ROBERT R. KRAUTER, Burial Permit Officer

Spec.—1-10-21—M&T—1500 Bks.

Trzaska ✓

HEALTH DEPARTMENT CITY OF BALTIMORE

D 80439

CERTIFICATE OF DEATH.

46

D 80439

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2904 Elliot ST., 1 WARD)

2-FULL NAME Josephine Trzaska

(a) RESIDENCE NO. 2904 Elliot ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Trzaska

6 DATE OF BIRTH (month, day, and year) July 3 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Rytel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Anna Rytel

(Address) 2904 Elliot Street

15 Filed NOV 1 1923, 19.. ROBERT A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 23, to Oct 30, 19 23, that I last saw h[illegible] alive on Oct 30, 19 23, and that death occurred, on the date stated above, at 5 10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/5/23

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Thomas J. Watts, M. D.

19 (Address) 437 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov. 2 19 23

20 UNDERTAKER	ADDRESS
John B. Weber	803 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80440

D 80440

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gabriel Alfano Alfano

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Rural

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Italy

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Italy

14 Informant Municipal Hospital Records.

(Address)

15 Filed NOV 1 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 16, 19 23, to October 31, 19 23, that I last saw h- alive on October 30, 19 23, and that death occurred, on the date stated above, at 9:00 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis

C. N. S. Syphilis (General Paresis)

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude G. Horne M. D.

10-31 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 2 1923

20 UNDERTAKER Wendell Dippell & Son — ADDRESS 37 Shm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80441 38 D 80441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Mason

(a) RESIDENCE NO. 857 Lemon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Mason

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Mason

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 26, 19 23, to October 30, 19 23, that I last saw h in alive on October 30, 19 23, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

CVS Syphilis (Secondary)

Coma

(duration) X yrs. 3 mos ds. (Autopsy)

CONTRIBUTORY Bronchopneumonia (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Hoffman, M. D.

10-31-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Nov 2 1923

20 UNDERTAKER Brown-Fleischmann-Lemmon Co

ADDRESS 1900

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 ✓ D 80442

D 80442

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 Frederick Ave ST., 19 WARD)

2-FULL NAME James A. McColgan

(a) RESIDENCE NO. 1837 Frederick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	49	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael McColgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Mary A. O'Byrne

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Jessie Perkins
(Address) 837 Frederick Ave.

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER,
NOV 1 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to Oct 31 1923,
that I last saw him alive on " " 1923
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma - tongue

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Auto intoxication

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edw J Coolahan M. D.

11/ , 1923 (Address) 3.4 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 2nd 1923
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St
per J J Cowan	

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80443

CERTIFICATE OF DEATH.

101-001

D 30443

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Ward) ST., 21 WARD)

2-FULL NAME Catherine Sower

(a) RESIDENCE NO. 1137 Ward ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John A. Sower

6 DATE OF BIRTH (month, day, and year) Unknown 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Colt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anne Hollyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Geo A. Gesner.
(Address) 1137 Ward St —

15 Filed NOV 1 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1923, to Oct. 31, 1923, that I last saw h-r alive on Oct 31, 1923 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Manley Strong, M. D.

NOV 1 1923 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov. 3 1923

20 UNDERTAKER John J. Cowan & Son

ADDRESS 701 Hollins St

per J. J. Cowan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80444

CERTIFICATE OF DEATH.

X 123 D 80444

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 10 WARD)

2-FULL NAME Edward Velker

(a) RESIDENCE NO. Glenwood Avenue, Catonsville ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Marie Velker

6 DATE OF BIRTH (month, day, and year): April 28 1883

7 AGE: 40 Years 6 Months 2 Days. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Thomas Thomson Comp.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fredrich J Velker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Vinnie Shust

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Anna Maria Velker

(Address): Glenwood Ave Catonsville Md.

15 Filed NOV 1 - 1923, ROBERT R. KRAUSE, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1923, to Oct. 30, 1923,

that I last saw him alive on Oct. 30, 1923,

and that death occurred, on the date stated above, at 9:20 p m.

The CAUSE OF DEATH* was as follows:

Embolism

pond

(duration) yrs. mos. 5 min ds.

CONTRIBUTORY (Secondary) Cholecystotomy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 28, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Henry V. P. Wilson Jr. M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 3 1923

20 UNDERTAKER: Louis Heemann — ADDRESS: 32 S Broadway

Burial Permit Issued

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gall Stones

Spec.—1-10-21—M&T—1500 Bks.

D 80445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80445

21-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME Thomas D. Keogh

(a) RESIDENCE NO. 209 N. Front St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Keogh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gatch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from October 29, 1923 to October 30, 1923, that I last saw h[illegible] alive on October 30, 1923, and that death occurred, on the date stated above, at 8:55 P.M.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + Lab.

(Signed) Claude A. Price, M. D.

10-31 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity St Cemetery	Nov 2 1923
20 UNDERTAKER	ADDRESS
Louis Heemann	32 S Broadway

ROBERT R. KRAUTER

NOV 1 - 1923

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80446

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1682 Yarley Ave St.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Hirsch

(a) RESIDENCE. No 1682 Yarley Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hirsch

6 DATE OF BIRTH (month, day, and year) Nov. 11 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Parkwood Cem.
(Address)

15 Filed . 19 . Registrar

OCT 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1923, to Oct 30, 1923.

that I last saw h in alive on Oct 30, 1923.

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) Samuel P. Erbaugh M. D.

Oct 31 1923 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem.

DATE OF BURIAL: Nov 2 1923

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Frederick Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80447

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp. St., 11 WARD)

2-FULL NAME Miss Emily K Richardson

(a) RESIDENCE NO. 1319 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward J Richardson

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Pennard

13 BIRTHPLACE OF MOTHER (city or town) Chestertown
(State or country) Maryland

14 Informant Annie M. Cannon
(Address) 1319 Madison Ave

15 Filed , 19 Registrar

Burial Permit Clerk

NOV 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-23

17 I HEREBY CERTIFY, That I attended deceased from 10-28-23 19 , to 10-31-23 , 19 ,

that I last saw h alive on 10-31-23 , 19 ,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Imp. Bronchopneumonia

(over)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? Md Gen Hosp

Did an operation precede death? No Date of 10-9-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path Proof

(Signed) Jno A Donaghue , M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem DATE OF BURIAL Nov 3 1923

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80448

CERTIFICATE OF DEATH.

73

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 29 W Hamilton Ave ST., 27 WARD)

2-FULL NAME Mary A Mc Quaid

(a) RESIDENCE NO. 29 W Hamilton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Thomas McQuade

6 DATE OF BIRTH (month, day, and year): Feb. 28 1865

7 AGE: Years 58; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 31

(c) Name of employer

9 BIRTHPLACE (city or town) Lake Burg. (State or country) Edward Island Canada

PARENTS

10 NAME OF FATHER Edward Kelley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Brigt. Kelley.

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Edward Mc Quaid. (Address) 29. W. Hamilton Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923 to Oct 31, 1923

that I last saw h alive on Oct 31, 1923

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Paraplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

....., 19 (Address) 4 W Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 11/2 1923

20 UNDERTAKER: George & Ruth — ADDRESS: 1735 Harford Ave

NOV 1 1923 Robert P. Harrison, Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statemen OCCUPA-TION is very imprtant. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 E. North ave ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Harris

(a) RESIDENCE No. 227 E. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Wyman Harris

6 DATE OF BIRTH (month, day, and year) Mch 31 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Rev Edward N. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Sarah F. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Ida H. Mealy

(Address) 227 E. North ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from August , 1923, to Oct 31 , 1923, that I last saw him alive on Oct 31 , 1923, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) George H. Carr, M. D.

, 19 (Address) 17 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Nov 2 1923

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 1-1923 Robert F. Harrison, Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 80450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80450

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 343 Warren Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W Lewis

(a) Residence No. 343 Warren Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Margaret A Lewis

6-DATE OF BIRTH (month, day and year) July 4 1866

7-AGE 57 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mariner

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas H Lewis

11-BIRTHPLACE OF FATHER (city or town) A.A.Co (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah A Abey

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs Margaret A Lewis

(Address) 343 Warren Ave

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 29/923

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 ..., 192.. to Oct 29 19..

that I last saw h.. alive on Oct 29 19..

and that death occurred, on the date stated above, at 9 55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

, 19.. (Address) 1 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet	Nov 2, 1923
20-UNDERTAKER,	ADDRESS
John F Denny	715 Light St

Robert P. Harrison,

Burial Permit Clerk.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chronic Nephritis

D 80451 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 001 D 80451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 74

City of BALTIMORE: (No. 617 N. Appleton St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry C. Linstid

(Residence in Baltimore: No. 617 N. Appleton St. St.; yrs. 4/ mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

6-DATE OF BIRTH: Oct. 31, (Month) (Day) 1841 (Year)

7-AGE: 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): farmer

9-BIRTHPLACE. (State or Country): Md.

PARENTS

10-NAME OF FATHER: Landy Linstid

11-BIRTHPLACE OF FATHER. (State or Country): Md.

12-MAIDEN NAME OF MOTHER: H. Bright

13-BIRTHPLACE OF MOTHER. (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Linstid Jr

(Address) 617 N. Appleton St

15-

Filed 19?

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

NOV 1 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 31, (Month) (Day) 192? (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) J. S. Hemmeter M. D. (Coroner)

Nov. 1, 192? (Address) 202 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill — DATE OF BURIAL: Nov 3 1923

20-UNDERTAKER: John F Denny — ADDRESS: 715 Light st

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80452

CERTIFICATE OF DEATH.

181-2001 D 80452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Lakewood Ave ST., 1 WARD)

2-FULL NAME Louisa Smith

(a) RESIDENCE NO 519 N. Lakewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Smith

6 DATE OF BIRTH (month, day, and year) April 27/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer 0"?

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Josiah Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Julia Cromwell
(Address) 521 N. Lakewood Ave.

15 Filed NOV 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30/1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation
Accidental- coffee pot boiled over and extinguished flame.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Davis, M. D. (Coroner.)

Nov 1/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL Nov 2 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80453

CERTIFICATE OF DEATH.

1923 003

D 80453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 466 E. Cross. ST. 24th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Howard Herring

(a) RESIDENCE. No. 466 E. Cross ST. 24th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE shall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

10 NAME OF FATHER Richmond P. Herring

11 BIRTHPLACE OF FATHER (city or town) Alexandria (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret E. L. Gibson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Mother (Address) Margaret Gibson Herring 466 E. Cross St.

15 Filed NOV 2 - 1923 19 MICHAEL E. KRAUS Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923, to Nov 1, 1923 that I last saw him alive on Oct 31, 1923 and that death occurred, on the date stated above, at 330 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformations.

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) Henry F. Buettner, M. D.

. 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. C. Co — DATE OF BURIAL: 11/2 '23

20 UNDERTAKER: J. J. Fahey Sons. — ADDRESS: 1348 Light St

Spec.—1-10-21—M&T—1500 Bks.

Ruch

D 80454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 80454

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 S. 7th St., 7 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ruch

(a) RESIDENCE NO. 808 S. 7th St., 26 Ward 26

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 30- 1923

7 AGE: Years ... Months ... Days 2 ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Lewis Ruch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Northumberland Pa

12 MAIDEN NAME OF MOTHER: Anna Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Lewis C. Ruch
(Address) 808 S. 7th st

15 Filed ..., 19... NOV 2 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Nov 1, 1923

that I last saw him alive on Oct 31, 1923

and that death occurred, on the date stated above, at 4.30a m.

The CAUSE OF DEATH* was as follows:

7 Month Foetus non viable

.....(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Frances Tatlow, M. D.

Nov 1, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Nov. 2 1923

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 S. Wolfe St.

INFORMATION CONCERNING THIS DEATH IS REQUIRED BY LAW. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80455

CERTIFICATE OF DEATH.

16 181-007

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2741 Prospect St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie L. Touchard

(Residence in Baltimore: No. 2741 Prospect St. St.; yrs. mos. ds. 25)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. October 7 1898
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Conrad Touchard

11-BIRTHPLACE OF FATHER. (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Loretta Kelly

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Conrad Touchard
(Informant)

2741 Prospect St.
(Address)

15-

Filed NOV 2 - 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 1 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental suffocation

(Found dead in bed alongside of mother)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov 1 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Nov 7 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Bath St.

N. B.—Every item of information should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80456

CERTIFICATE OF DEATH.

162 D 80456

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 3rd ST. No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Piccolli

(a) RESIDENCE No. 1328 3rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 31, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Bastiano Piccolli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Katherine Barrini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Bastiano Piccolli

(Address) 1328 3rd St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Oct 31, 1923, that I last saw him alive on Oct 31, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Electrocusion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Twin Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. W. Schleeder, M. D.

Nov 1, 1923 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Nov 3 1923

20 UNDERTAKER John Ulrich

ADDRESS 200 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 9 1923 ROBERT R. KRAUTER BUREAU VITAL STATISTICS

Spec.—1-10-21—M&T—1500 Bks.

D 80457 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 80457

CERTIFICATE OF DEATH. 145 - 80457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S 3rd ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Piccoli'

(a) RESIDENCE NO. 13 S 3rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bastiste Piccoli'

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Bastiste Piccoli'

(Address) 13 S 3rd St

15 Filed NOV 2 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Oct 31, 1923, that I last saw h~~er~~ alive on Oct 31, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 1 ds. hr

CONTRIBUTORY (Secondary) Pneumonia Lung Both

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Callender, M. D.

11/1, 1923 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 3 1923
20 UNDERTAKER John Ellerich	ADDRESS 208 Ericsson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 80458

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 80458

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 834 Hampden ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. F. Jordan

(a) RESIDENCE. No. 834 Hampden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colord

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecelia Jordan

6 DATE OF BIRTH (month, day, and year): [illegible] 1885

7 AGE: 38 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Pennsylvania R.R. Co

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Benjamin Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ann Lark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Euclid Jordan
(Address): 834 Hampden St

15 Filed [illegible], 19

Registrar

NOV 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923, to Oct 31, 1923, that I last saw him alive on Oct 30, 1923 and that death occurred, on the date stated above, at 12 M. a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Exhaustion

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? L

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Hughes M. D.

Oct 31, 1923 (Address) 1413 E. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manassa. Va

DATE OF BURIAL: Nov. 3 1923

20 UNDERTAKER: Lancaster, Va

ADDRESS: 142 W. Hill St

John N. Toadvine

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80459

CERTIFICATE OF DEATH.

+ 113 D 80459

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Williams

(a) RESIDENCE NO. Edgemere, Md ST., ... WARD England

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —— yrs. —— mos. 14 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Aug 7-1923

7 AGE — Years: — Months: 2 Days: 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer): H

(c) Name of employer: H

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Sydney Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ethel Philpott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Record

(Address): Johns Hopkins Hosp.

15 Filed NOV 2 1923, 19..... ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 19 23, to Oct 30, 19 23, that I last saw h... alive on Oct 30, 19 23, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery) 6 weeks.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Over!

.....(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) A.H. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews Cemetery — DATE OF BURIAL: Nov 2 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W Lombard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Baby had a congenital malformation of the heart - true dextracardia - apex of heart on rt. side without transposition of the lives. Autopsy showed transposition of the great vessels, so that the aorta was in front of the pulmonary artery. There was no interventricular septum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80460 — CERTIFICATE OF DEATH. — 1855 D 80460

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Md. Gen. Hosp. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Hudnall

(Residence in Baltimore: No. Mila, Va. St.; yrs. ..... mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: June 17 (Month) (Day) 1878 (Year)

7-AGE: 45 yrs. 4 mos. 14 ds. If LESS than 1 day, ... hrs. or ... mins.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Pressman
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country): Va.

PARENTS

10-NAME OF FATHER: Napoleon Hudnall

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Fannie Hudnall

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Hudnall

(Address) Mila, Va.

15- Filed NOV 2 - 1923 19.. ROBERT P. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct. 31 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of 12th Dorsal vertebra & laceration of spinal cord.

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Fell through hatch in factory floor.

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Nov. 1, 1923. (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Irvington Lancaster Co. Va. DATE OF BURIAL: Nov 2 1923

20-UNDERTAKER: Lane & Cook ADDRESS: 502 E. 20th St.

c/o Robert E. Lanier Via Va. R. R. & N. Steamboat Co.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D 30461

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST., 9 WARD)

2-FULL NAME Philip Haberlein

(a) RESIDENCE NO. 2257 Cecil Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~): Mary

6 DATE OF BIRTH (month, day, and year) May 22, 1851

7 AGE: Years 72 | Months 5 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ? Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ? Clothing

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: George Haberlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Margaret Brannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mary Haberlein

(Address) 2257 Cecil ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1923, to Oct 31, 1923, that I last saw him alive on Oct 31, 1923 and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Pyemia prostatic hypertrophy ~~with complications~~

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct 29, 1923

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Eugene L. Shaw, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lutheran Cemetery Middle Falls N.Y. DATE OF BURIAL 1923

20 UNDERTAKER: Louis Leland Jr. ADDRESS: Wm Cook 502 E 138 St

A. B. WHITE BURIAL, MAUSOLEUM AND CREMATORY RECORDS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 80462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 E. 27th St. ST., 9 WARD)

2-FULL NAME Prompelia H. Spicer

(a) RESIDENCE NO. 527 E. 27th St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Spicer

6 DATE OF BIRTH (month) March 12th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	82	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Spicer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Earle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Mary Sherman

(Address) 527 E. 27th St. City

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1923, to Nov 1st, 1923, that I last saw h— alive on Nov 1st, 1923, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo. Hurlock Gotwals Asst. M. D.

11/1/1923 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Nov 3 1923

20 UNDERTAKER Wm. Cook for E. Jones & Co

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80463

HEALTH DEPARTMENT—CITY OF BALTIMORE

Murgatroy
Tuesday 7:30

74-001 D 80463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Winston Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Tarman

(a) RESIDENCE NO. 809 Winston Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife~~ of Elizabeth Tarman

6 DATE OF BIRTH (month, day, and year) July 11-1859

7 AGE: Years 64 | Months 7 | Days 11 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Grocer - Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York

PARENTS

10 NAME OF FATHER: John T. Tarman

11 BIRTHPLACE OF FATHER (city or town) (State or country): York

12 MAIDEN NAME OF MOTHER: Wagaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York

14 Informant: Mrs. F. Lang

(Address): 4707 York Rd.

15 Filed NOV 2 - 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1923, to Oct 31st, 1923, that I last saw h~ alive on Oct 31st, 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ? yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Murgatroyd M.D., M. D.

11/1/1923 (Address) 40 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 3 1923

20 UNDERTAKER: Wm Leon & Son — ADDRESS: Irving Av

NOTE.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE RECORDS PERMANENTLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 80464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 80464

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Blackwell

(a) Residence No. 1509 Brevard St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1881

7-AGE: 42 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md

PARENTS:

10-NAME OF FATHER: Andrew Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER: Annie Banks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md.

14- Municipal Hospital Record (Informant)

(Address)

15-

Filed ..... 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1923 to October 30 1923

that I last saw h... alive on October 30 1923

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

& General Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Sub. Ovarian Abscess

Bilateral (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 30, 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Section

(Signed) M. J. Fulton M. D

10-31-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Calvary Cem	11/3/23
20-UNDERTAKER,	ADDRESS.
Thurston White	1131 W Fay

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc. *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably Gonococcus Infection.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80465

CERTIFICATE OF DEATH.

57 D 80465

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 N. Fremont Ave. St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Jane Collins

(Residence in Baltimore: No. 839 N. Fremont Ave. St.; 70 50 yrs., 1 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: October 2, (Month) (Day), 1853 (Year)

7-AGE: 70 yrs. 1 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

037

9-BIRTHPLACE, (State or Country): Maryland-Dorchester Co.

PARENTS.

10-NAME OF FATHER: John Moore

11-BIRTHPLACE OF FATHER (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. M. Collins

(Address) Cambridge Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 25 1923, to Nov. 2 1923, that I saw her alive on Nov. 2 1923 and that death occurred, on the date stated above, at 5.40 A m..

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 12 yrs. ? mos. ? ds.

(Signed) John L. Stansbury M. D.

Nov. 2 1923 (Address) 1037 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 2 mos. 7 ds. In the State 70 yrs. 1 mos. 0 ds.

Where was disease contracted, if not at place of death? at Cambridge Md.

Former or usual residence: Academy St; Cambridge

19-PLACE OF BURIAL OR REMOVAL: Cambridge Md

DATE OF BURIAL, Nov. 4, 1923

20-UNDERTAKER: Josiah Leyden

ADDRESS: 160 W North Ave

NOV 2 - 1923

ROBERT R. KRAUTER, Registrar of Vital Statistics

Burial Permit

U. S. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80466 D 80466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST., 2800 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Betzel

(a) RESIDENCE NO. 10 Fort Washington N.Y. city ST., WARD) New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., If of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Mr Betzel

6 DATE OF BIRTH (month, day, and year) about 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	65	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New City - N. Y.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland (?)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland (?)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Baltimore Md

15 Filed NOV 2 - 1923, 19... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 15-th, 1923, to Nov 1, 1923,

that I last saw h... alive on Nov 1, 1923,

and that death occurred, on the date stated above, at 7.55 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

Not Known

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Psychosis - Abt (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New York city

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy - New York.

DATE OF BURIAL Nov 2, 1923

20 UNDERTAKER STEVENS & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 100 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80467

CERTIFICATE OF DEATH.

90 D 80467

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1645 E. Fayette St St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Goodman

(a) Residence No. 1645 E Fayette St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) — 1878

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer): House

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore

15- Filed, 192

ROBERT R. KRAUTER, Registrar.

NOV 2 - 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-2-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 19 23 to Nov 2 19 23

that I last saw him alive on Nov 2 19 23

and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Hypertension - Arteriosclerosis

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism 10 days

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

11/2, 1923 (Signed) Bond Faughn M. D.

(Address) 1000 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Lebanon DATE OF BURIAL. Nov 2 19 23

20-UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80468

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH JOHNS HOPKINS HOSP

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 8 WARD)

2-FULL NAME Kenneth Elliott

(a) RESIDENCE NO. 1613 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 1923.

7 AGE — Years: 0 — Months: 4 — Days: 17 — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Charles Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records

(Address)

15 Filed , 19 Registrar

NOV 2 - 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1923, to Oct 31, 1923, that I last saw him alive on Oct 31, 1923 and that death occurred, on the date stated above, at 1:40 P. M.

The CAUSE OF DEATH* was as follows:

Post Operative Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of Testicle

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-29-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Sewell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 2 1923

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1938 E. Lafayette

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80469

D 80469

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Pennington Ave ST., 25 WARD)

2-FULL NAME Carrie W. Mallonee

(a) RESIDENCE NO. 914 Pennington Ave ST., 25 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced (or) WIFE of Walter Mallonee

6 DATE OF BIRTH (month, day, and year) July 16-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Mundie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virgie Carmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Eva Thomas (Address) 914 Pennington Ave

15 Filed NOV 2 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to Oct 31, 1923, that I last saw her alive on Oct 30, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William Lofe M. D.

Oct 31, 1923 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Nov. 2 1923

20 UNDERTAKER Margaret S. Flynn ADDRESS 422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80470

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 N. Clinton (ave) ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bichy

(a) RESIDENCE NO. 644 Clinton ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Chas. E. Bichy

6 DATE OF BIRTH (month, day, and year) May 14 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tour guide

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Geo. Reilly

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Bridget Divine

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Herman Bichy (Address) 644 Clinton (ave)

15 Filed , 19 Registrar

NOV 2 1923 ROBERT R. KRAUS Registrar

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1923. to Oct 30 1923.

that I last saw h[illegible] alive on Oct 30 1923.

and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Omentum

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Sept. 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Geo. W. Hemmeter, M. D.

11-1, 1923. (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11 3 1923

20 UNDERTAKER H. Brauning's Son

ADDRESS 171 Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80471

CERTIFICATE OF DEATH.

44 D 80471

1-PLACE OF DEATH St Agnes Hosp

CITY OF BALTIMORE: (No. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Balzer

(a) RESIDENCE NO. 2565 N. Lafayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Jos Balzer

6 DATE OF BIRTH (month, day, and year) Feb. 5. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	71	11	7	

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Jos Balzer (Address) 2716 Hoffman Ave

15 Filed NOV 2 - 1923, 19 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 — , 1923, to Nov 1 — , 1923, that I last saw h~~er~~ alive on Nov 1 — , 1923, and that death occurred, on the date stated above, at 6.40 a~~m~~m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 13-23

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H.B. Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11 - 5 1923

20 UNDERTAKER W. C. Brannigan Son

ADDRESS 174 Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80472

CERTIFICATE OF DEATH.

38 D 80472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Gallimore

(a) RESIDENCE NO 423 N. Eden St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Gallimore

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) common

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston West Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Clara Gallimore (Address) 423 N. Eden St.

15 Filed NOV 2 - 1923 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphillitic Aortitis

(Autopsy at Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. E. Cullen, M. D. (Coroner.)

Nov. 1/23. 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Nov. 2 192 3

20 UNDERTAKER Milton Davis ADDRESS 215 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 80473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 80473

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Elsinore Ave (Govane St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Adams McGlone

(Residence in Baltimore: No. 431 Elsinore St.; 63 yrs., 2 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug 13, 1860 (Month) (Day) (Year)

7-AGE, 63 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: R R Accountant
(b) General nature of industry, business, or establishment in which employed (or employer): R R

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John J. McGlone

11-BIRTHPLACE OF FATHER (State or Country), U.S.A.

12-MAIDEN NAME OF MOTHER Jane Reed

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma M. McGlone

(Address) 431 Elsinore Ave.

15-

Filed....., 191.....

NOV 2 - 1923

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1923, to Oct 31 1923, that I saw him alive on Oct 31 1923, and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

L. hemiplegia 2 hrs

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. ....mos. ....ds.

(Signed) Geo. A. Hockman M. D.

Nov 1, 1923 (Address) 5835 Fairfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Nov. 3, 1923

20-UNDERTAKER Chas. G. Black — ADDRESS 1420 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 30474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 30474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Carrollton Ave ST. 18 WARD)

2-FULL NAME Ulrich Littell Baker

(a) RESIDENCE No. 404 N. Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella M. Baker

6 DATE OF BIRTH (month, day, and year) Sept 14 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Business Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Local 28 086 Union

(c) Name of employer Sheet metal workers

9 BIRTHPLACE (city or town) Richmond (State or country) Va

PARENTS

10 NAME OF FATHER Walter Baker

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Evalista Hooper

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs. Estella M. Baker

(Address) 404 N. Carrollton Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Nov 1, 1923,

that I last saw him alive on Oct 30, 1923,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard C Brach M. D.

19 (Address) 2231 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudan Park Cemetery	11/3 1923

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Lanvale

REMEMBER, WITH CAREFUL CARE THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80475

CERTIFICATE OF DEATH.

114

D 80475

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sisters of Chas Home St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Henderson

(a) Residence No. Preston & Caroline Sts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Henderson

6-DATE OF BIRTH (month, day and year) Feb 29—1852.

7-AGE. 71 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Benjamin Henderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Sister Florence

(Address) Sisters of Chas Home

15- Filed 19 Registrar.

NOV 2-1923 ROBERT R. KRAUTER, Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/1/23

17- I HEREBY CERTIFY, That I attended deceased from 10/10, 1923, to 11/1, 1923, that I last saw h. alive on 10/30 1923 and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. V. Bernadou M. D

11/1, 1923 (Address) 914 E Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Swartz Trinity Nov 3, 1923

DATE OF BURIAL.

20-UNDERTAKER: H. C. Wiedefeld

ADDRESS: 914 Greenmt Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 80476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80476

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Baker St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Parsons.

(Residence in Baltimore: No. 2708 Baker. St.; 45 yrs., 10 mos. 26 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) 6 (Day), 1878 (Year)

7-AGE, 45 yrs. 10 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Claim agent &c
(b) General nature of industry, business, or establishment in which employed (or employer). Empire Laundry

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. Parsons

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Ella Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie M. Parsons

(Address) 2707 Baker St

15-

Filed....., 191.....

Registrar.

NOV 2 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 1 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Nov. 1 1923, that I saw him alive on Oct 31 1923, and that death occurred, on the date stated above, at 4 1/4 P m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 5 ds.

(Signed) George E. Shannon M. D.

Nov. 1, 1923 (Address) 700 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, Nov. 5, 1923

20-UNDERTAKER Harry W. Ehlen

ADDRESS 1900 W. Northan

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80477

CERTIFICATE OF DEATH.

129

D 80477

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4008 Norwood Av ST. 28 WARD)

2-FULL NAME Jennie Barber

(a) RESIDENCE NO. 4008 Norwood Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., If of foreign birth? 34 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Emory E Barber

6 DATE OF BIRTH (month, day, and year) May 3 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co Md
(State or country)

PARENTS

10 NAME OF FATHER John G Frager

11 BIRTHPLACE OF FATHER (city or town) Balto Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Gober

13 BIRTHPLACE OF MOTHER (city or town) Balto Co Md
(State or country)

14 Informant Emory E Barber
(Address) 4008 Norwood Av

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan-15- , 1923, to Oct 31 , 1923.

that I last saw her alive on Oct 31 , 1923,

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic with Nephritis chronic

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

11/1, 1923 Address 2702 Gorsuch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cem Arcadia Md

DATE OF BURIAL Nov 3 1923

20 UNDERTAKER Harry W Ehlen

ADDRESS 1964 W North Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 2-1923

Robert P. Harrison
Burial Permit Clerk

Spec.—1-10-21 M&T—1500 Bks.

D 80478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80478

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 Hilton St. 70 WARD)

2-FULL NAME John P. Stenner

(a) RESIDENCE NO. 2141 Hilton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret B. Stenner

6 DATE OF BIRTH (month, day, and year): Aug 11—1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. A.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: John Stenner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Gertrude Mellor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles H. Stenner

(Address): 1852 W. Mulberry St.

15 Filed ... 192... 19 ... Registrar

NOV 2 1923 Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Oct 31, 1923,

that I last saw h... alive on Oct 30, 1923,

and that death occurred, on the date stated above, at 2-45 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) F. Howard, M. D.

Nov 2 19 (Address) F. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Nov. 3 1923

20 UNDERTAKER: Geo. L. Schwab

ADDRESS: 401 Bulk St.

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80479

101-001 ✓ D 80479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. ..... ST., ... 18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Kane

(a) RESIDENCE NO. 1060 W Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 15-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John J. Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Genevieve Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John J. Kane
(Address) 1060 W. Fayette St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-31, 1923, to 11-1, 1923, that I last saw him alive on 11-1, 1923, and that death occurred, on the date stated above, at 6 25 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Bilateral)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab & Phys Exam

(Signed) H V Harper, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 3 1923

20 UNDERTAKER Geo. L. Schwab — ADDRESS 1101 Buck. Ave.

NOV 2-1923 Burial permit clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 80480 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80480

CERTIFICATE OF DEATH. 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2845 N Calvert ST. 17 WARD)

2-FULL NAME James Monroe Jacques

(a) RESIDENCE NO. 2845 N Calvert St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred See Jacques

6 DATE OF BIRTH (month, day, and year) June 27-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	72	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Financier

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Richard Saws See

(Address) 2843 N. Calvert St

15 Filed NOV 2 1923, 19 Robert P. Garrison, Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31st, 1923 to Oct 31 1923, that I last saw h[illegible] alive on Oct 31st 1923, and that death occurred, on the date stated above, at 11.00 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) 6 hours yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferson Buell M. D.

Nov 2nd 1923 (Address) 1944 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov 3rd 1923

20 UNDERTAKER Henry H Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80481 D 80481

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McNaney

(a) RESIDENCE NO. 730 S. Wolfe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McNaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records.

(Address)

15 Filed NOV 2 1923, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 19 23

17

I HEREBY CERTIFY, That I attended deceased from October 31, 19 23, to October 31, 19 23,

that I last saw h in alive on October 31, 19 23,

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Harry E. Handley, M. D.

11/1, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Phila. Pennsylvania

DATE OF BURIAL Nov 2 23 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 106 W. NORTH AVE.

INFORMATION CONCERNING THIS DEATH IS CONFIDENTIAL AND FOR USE OF HEALTH OFFICIALS ONLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 80482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80482

X 148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9 WARD)

2-FULL NAME Irene Elliott

(a) RESIDENCE NO Bradshaw, Md. ST., ... WARD Bradshaw Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June.5,1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David Davidson
(Address) Upper Falls Md

15 Filed 1923, 192 Robert P. Harrison, Registrar

Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Post Partum Eclampsia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. N. Patten, M. D.
(Coroner.)

Nov 2/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bradshaw md

19 PLACE OF BURIAL, CREMATION OR REMOVAL Upper Falls. Md. DATE OF BURIAL 11—4 1923

20 UNDERTAKER E H B Harle ADDRESS 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80483 14-001 D 80483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables St. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cecelia Bryan

(a) RESIDENCE NO. Home for Incurables ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Apl-3-1866.

7 AGE: Years 57 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queenstown Md.

PARENTS

10 NAME OF FATHER: George Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Queenstown Md

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rockhall Md.

14 Informant: Home for Incurables

(Address): Guilford Ave & 21st.

15 Filed . 19 Registrar

NOV 2-1923 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 19 22 to Nov 1, 19 23.

that I last saw her alive on Nov 1, 19 23,

and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Arteria Hypertension —
Cerebral hemorrhage —

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary): Chronic Infectious Arthritis

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) Wm B Mayo M. D.

11 2, 1923 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 11/3/23

20 UNDERTAKER: H E Hughes

ADDRESS: 1000 E. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 80484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80484

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH University Hospital 17

CITY OF BALTIMORE: (NO.) ..... ST. ..... (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Raymond

(a) RESIDENCE NO. 612 Bradley St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Blk	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Raymond

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Husband

(Address) 612 Bradley St

15 Filed ..... , 19 .....

Registrar

NOV 2-1923

Robert P. Garrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1923, to Nov. 1, 1923.

that I last saw her alive on Nov. 1, 1923,

and that death occurred, on the date stated above, at 10½ a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart post operative.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Left Cystis ovary

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov. 1-1923

Was there an autopsy? .....

What test confirmed diagnosis? Operative findings

(Signed) R. Clyde ..... M. D.,

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gilboa

DATE OF BURIAL 11-5 1923

20 UNDERTAKER David Easton

ADDRESS 916 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80485

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-001 D 80485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 N Lexington St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME D and Turner

(a) RESIDENCE NO. 1136 N Lex St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24.	-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER D. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Celia Marshel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Owner Turner
(Address) 1136 N. Lexington

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Bronchites

(Duration) 1 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. — ds.

(Signed) Geo C Blades, M. D.
Nov 1 23 192 (Coroner) (Address) 1436 Broad

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-5 192 3

20 UNDERTAKER Dennis Eustace

ADDRESS 1436 Druid

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert P. Harrison, Local Health Officer.

0 2-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80486 1-001 ✓ D 80486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Whiteford ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Thomas

(a) RESIDENCE NO. 807 Whiteford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Thomas

6 DATE OF BIRTH (month, day, and year): 8/16 1872

7 AGE: Years 27 Months Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): ~ 037

(c) Name of employer: ~

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Howlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Flora Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Howlett (Address) 2200 Eastern Ave

15 Filed NOV 2 1923, 19 Registrar Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 1923, to Oct 31st, 1923, that I last saw h alive on Oct. 29th, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Typhoid Fever

(duration) yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary) ~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chew, M. D.

Nov. 2, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem DATE OF BURIAL 11-3-1923

20 UNDERTAKER: Dan'l Gaylor ADDRESS 916 Eare

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80487

CERTIFICATE OF DEATH.

D 80487

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 22 WARD)

2-FULL NAME Wladyslaw Zielinski.

(a) RESIDENCE No 41 Third Ave. East Brooklyn, WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 20 yrs. ---- mos. ---- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed or divorced HUSBAND of (or WIFE of) Rozalia Zielinski.

6 DATE OF BIRTH (month, day, and year) March -- 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	7	-----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Interocean Oil Co.

040

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph Zielinski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Rozalia Zielinski. (wife)
(Address) 41 Third Ave East Brooklyn

15 Filed 0[illegible]2-1923. 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned about the face and body.
Explosion of a gasoline agitator.
Accidental Death.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mns. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Nov, 2, 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Accident, Interocean Oil Co. 10/31/28.
Former or usual residence East Brooklyn.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem.	Nov 3 1923
20 UNDERTAKER	ADDRESS
A. Zakrowski	[illegible]

Spec—12-23-21—E.B.R.S.—400 Pks.

D 80488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80488

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1011 Ridgley St., 21 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt Clarke Russell

(a) Residence No. 1011 Ridgley St., 21 Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 9 23

7-AGE. yrs. 1 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Wm T Russell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Emma Vettros

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Wm T Russell

(Address) 1011 Ridgley St

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year) Nov 2/23

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1923 to Nov 2 1923

that I last saw him alive on Nov. 1 1923

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John D. Schwamberger, M.D.

19 (Address) 11 West Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. | DATE OF BURIAL. Nov 3 1923

20-UNDERTAKER. Wm Cook | ADDRESS 502 E. Nat'l Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 2-1923

Robert P. Harrison,
Burial Permit Clerk.

Cor.—1-12-23—M&T—100 Bks.

D 80489

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 ✓ D 80489

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 W. Mulberry ST. 18 WARD)

2-FULL NAME Benj H. Van Matre

(a) RESIDENCE NO. 927 W Mulberry WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (

6 DATE OF BIRTH (month, day, and year) Jan 12-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer (

9 BIRTHPLACE (city or town) N. J.
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) ((

(State or country)

12 MAIDEN NAME OF MOTHER (((

13 BIRTHPLACE OF MOTHER (city or town) ((

(State or country)

14 Informant Hendrick L. Van Matre
(Address) 927 W. Mulberry St.

15 Filed ..... 192 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ..... find that said deceased came to his death ~~topsy or~~ inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Faulty Gas Hose attached

(duration) ..... yrs. ..... mos. .....

(Signed) H. H. Gunckel M. D.
(Coroner.)

11-2-, 1923 (Address) 119 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Centry Mem. DATE OF BURIAL 3, 1923.

20 UNDERTAKER Wm Cook ADDRESS 502 East Nattan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificate.

10 12-1923

Spec.—1-10-21 M&T 1500 Bks.

D 80490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00 D 80490

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4312 Ready Ave - ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wolf

(a) RESIDENCE No. 4312 Ready Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Wolf -

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph Wolf

(Address) 4312 Ready Ave

15 Filed NOV 3 1923, 19 Robert E. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1919, to Oct 31st, 1923.

that I last saw h... alive on , 19

and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Hardening of Arteries

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) old age

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Nov 2, 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/3/1923

20 UNDERTAKER J. J. Faber Sons

ADDRESS 1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80491

CERTIFICATE OF DEATH.

46 D 80491

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 N. Bradford St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludmila Kral

(Residence in Baltimore: No. 934 N Bradford St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Gulley

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Kral

(Address) 934 N. Bradford St.

15-

Filed ....., 191.....

Registrar.

NOV 3 - 1923

Robert P. Harrison, M.D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-10 1922, to Nov 2 1923 that I saw h[er] alive on Nov 1 1923 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Contributory Cardiac Dilatation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Fred Rumsey M. D.

Nov 7, 1923 (Address) 800 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Nov 5, 1923

20-UNDERTAKER	ADDRESS
Frank Barcelow	Woodland Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80492

CERTIFICATE OF DEATH.

179

D 80492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 Archer ST., 21 WARD)

2-FULL NAME Elizabeth Pinsney

(a) RESIDENCE NO. 631 archer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George N. Pinsney

6 DATE OF BIRTH (month, day, and year): —— 1887

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 631

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mary Ellen Savoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): George N. Pinsney 631 Archer st

15 Filed NOV 3 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct, 31, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept, 4, 1923, to Oct, 31, 1923, that I last saw her alive on Oct, 30, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis + myocarditis

(duration) 1 yr mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine ++

(Signed) Dan Francheim M. D.

(Address) 1220 W Lee st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 3 1923
20 UNDERTAKER	ADDRESS
Wm. G. H. Hofer	706 N. Amity st

Cor.—1-12-23—M&T—100 Bks.

D 80493

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80493

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Md. Gen. Hospital ST., WARD)

2-FULL NAME Anna Olivia Clark

(a) RESIDENCE NO 2223 Ruskin Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER James Schalmeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Anna Wirthelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Charles F. Clark
(Address) 2223 Ruskin Ave

15 Filed ....., 192 . Registrar

Robert P. Harrison,

NOV 3 1923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said — (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

crushing injuries to abdomen & left leg

20 minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) J. C. Kennedy, M. D. (Coroner.)

Nov. 15, 1923 (Address) 2702 Eutaw Pl

(*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Woodbrook & W. North Ave

Former or usual residence 2223 Ruskin Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 3 1923

20 UNDERTAKER M Tracey & Sons

ADDRESS 1522 W North

CAUSE OF DEATH: Please write plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 80494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80494

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apts. 3 B. ST., 13 WARD)

2-FULL NAME Rebecca Rice.

(a) RESIDENCE NO. Lake Drive & Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Rice

6 DATE OF BIRTH (month, day, and year) Feby. 27, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	84	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Steinberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss. Fannie Rice
(Address) Riviera Apts.

15 Filed ..... 19 ..... Registrar

NOV 3 1923 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/23. 19

17 I HEREBY CERTIFY, that I attended deceased from Oct. 30, 1923, to Nov. 2nd, 1923, that I last saw h[illegible] alive on Nov. 2nd, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Gen. Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

11/2 1923 (Address) 1920 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	11/4/23
20 UNDERTAKER David Sondheim	ADDRESS 118-20 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80495

CERTIFICATE OF DEATH.

44 D 80495

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apt ST., 13 WARD)

2-FULL NAME Harry C. Weiller

(a) RESIDENCE NO. Esplanade Apt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha G. Weiller

6 DATE OF BIRTH (month, day, and year): Dec 5/1858

7 AGE: Years 64 Months 10 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of Industry, business, or establishment in which employed (or employer): 071

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas Weiller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Steiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs C Weiller (Address) Esplanade Apt

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1923, to Nov 2 1923,

that I last saw him alive on Nov 2 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebroma of Liver

(duration) yrs. 3 mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Levinson M. D.

11/2/1923 (Address) 1920 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dust Shalom DATE OF BURIAL Nov. 4th 1923

20 UNDERTAKER: Hand Sondheim ADDRESS 1012 N Eutaw St

Webster

Spec.—1-10-21—M&T—1500 Blks.

D 80496 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D 80496

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 N Washington ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W Webster

(a) RESIDENCE NO. 634 N Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie E Webster

6 DATE OF BIRTH (month, day, and year) March 15-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	58	7	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Receiving clerk 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Steam Shipping Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James W Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mattie Webster

(Address) 634 N Washington St

15 Filed 1922 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10—1 19 23

17 I HEREBY CERTIFY, That I attended deceased from 10-1 . 19 23 . to 11-1 . 19 23

that I last saw him alive on 11-1 19 23

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surgery

(Signed) Fred Rupp M. D.

, 19 23 (Address) 600 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 5 1923

20 UNDERTAKER Wm F. Hartley

ADDRESS 810 N. Washington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT P. MATTHEWS, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80497 D 80497

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Wheatley

(a) RESIDENCE NO. 1722 Mc Culloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23. 1923

7 AGE — Years — Months — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Clarence Wheatley

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Cook

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant (Address) Hospital Records

15 Filed , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Nov 2, 1923, that I last saw h/ m alive on Nov 2, 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Pemphigus Neonatorum

(duration) .. yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) .. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilmer Krusen, M. D.

11/2 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 3 1923

20 UNDERTAKER: Commissioner Health. Per. Wm. S. Woodall

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICI... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of O... TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80498

CERTIFICATE OF DEATH. 164

D 80498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Boarman Ave St. 15 WARD)

2-FULL NAME Alexander C. Mentzel

(a) RESIDENCE NO. 2924 Boarman Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rosana Mentzel

6 DATE OF BIRTH (month, day, and year) Aug. 27 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	82	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meter Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 186

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Mentzel

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Worley

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Rosana Mentzel (Address) 2924 Boarman Ave

15 Filed NOV 3 1923, 19.... Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Nov 2, 1923, that I last saw him alive on Nov 2, 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 5 yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. D. Emrich, M. D.

11-3 1923 (Address) 5016 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem	Nov 5 1923
20 UNDERTAKER Roland S. Little	ADDRESS 2700 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80499

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Maryland Ave ST., 17 WARD)

2-FULL NAME Margaret Nunan

(a) RESIDENCE NO. 2406 Maryland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 40 yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	-----	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer ------

9 BIRTHPLACE (city or town) ------

(State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew George Nunan.

11 BIRTHPLACE OF FATHER (city or town) ------

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Daily

13 BIRTHPLACE OF MOTHER (city or town) ----

(State or country) Ireland.

14 Informant J. Edgar Gans.

(Address) Calvert Building City

15 Filed NOV 5 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov, 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Nov. 2, 1923, that I last saw h[illegible] alive on Nov. 2, 1923, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation with Pulmonary oedema (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) T. H. Mears, M. D.

, 19[illegible] (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov 5 1923

20 UNDERTAKER Henery W Mears & Son — ADDRESS 805 N Calvert

Spec.—1-10-21—MAT—1500 Bks.

167150

D 80500

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

146 D 80500

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Annie Wright

(a) RESIDENCE NO. 713 Pierce ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Noah Wright

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Elbat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant E. E. Duncan

(Address) Johns Hopkins Hospital

15 Filed ....., 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk

NOV 3 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1923, to Nov. 1, 1923, that I last saw h.. alive on Nov. 1, 1923 and that death occurred, on the date stated above, at 5.55 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

following puerperal infection

(duration) ..... yrs ..... mos ..... ds.

CONTRIBUTORY (Secondary) child birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) W. O'Shea, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hearlock Md

UNDERTAKER R. Ford McElderry

DATE OF BURIAL Nov 3 1923

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80501

CERTIFICATE OF DEATH.

159-00 D 80501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Winchester ST., 16 WARD)

2-FULL NAME Mark Burnett Frahley

(a) RESIDENCE No. 2826 Winchester ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard E. Frahley

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Md

12 MAIDEN NAME OF MOTHER Edith Marie Kirk

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country) Md.

14 Informant Howard E. Frahley

(Address) 2826 Winchester St., City

15 Filed ..... , 19 .....

Registrar

Robert P. Harrison, Burial Permit Clerk

NOV 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1923, to Nov 2nd, 1923, that I last saw him alive on Nov 2nd, 1923 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Physical exam.

(Signed) J. B. Culver Hauber, M. D.

11/3/23 (Address) 1901 Eutaw St., City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md.	Nov 5 1923
20 UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80502 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80502

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 216 E. Church St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Redell

(a) Residence No. 216 E. Church St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Mar.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm. D. Redell

6-DATE OF BIRTH (month, day and year): Dec 16-1869

7-AGE: 53 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer): at home 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS:
10-NAME OF FATHER: John James
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12-MAIDEN NAME OF MOTHER: Annie Burke
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-
(Informant): Wm. D. Redell
(Address): 216 E. Church St.

15-
Filed ..... 192... E. L. Harrison Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 3 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to Nov 2, 1923
that I last saw h.. alive on Nov 2 1923
and that death occurred, on the date stated above, at 5:40 p.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 d. ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(Duration) ....yrs. 18 mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.
Nov 3, 1923 (Address) 1 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — DATE OF BURIAL: Nov. 5, 1923

20-UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80503

D 80503

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1236 S. Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Wentworth

(a) Residence No. 1236 S. Charles St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Mar

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Oliver Wentworth

6-DATE OF BIRTH (month, day and year): July 7-1857

7-AGE: 66 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Saml. Hubbard

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Bridget McElhaney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto

14-

(Informant): Oliver Wentworth

(Address): 1236 S. Charles St.

15-

Filed NOV 3 1923 Robert P. Harrigan, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1923 to Nov. 1 1923

that I last saw h[illegible] alive on Nov. 1 19 23

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hamilton M. D

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery

DATE OF BURIAL: Nov 3 19 23

20-UNDERTAKER: F. C. Krause & Son

ADDRESS: 70 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

D 80504

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Northern Police station St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas A. Kaufmann

(Residence in Baltimore: No. 514 W. 33 St.; yrs. 51 mos. 6 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Sept (Month) 26th (Day) 1872 (Year)

7-AGE. 51 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Police Officer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmira P. Kaufmann

(Address) 514 W. 33rd st

15-

Filed ..... 192.....

Robert F. Garrison, Registrar.

NOV 3 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

Suicide

(Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Geo. H. Morris M. D. (Coroner.)

Nov 3 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Nov 5th 1923

20-UNDERTAKER, George Schilling & Sons — ADDRESS 1126 Monument st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80506 185 D 80505

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital St., 9 WARD)

2-FULL NAME Michael Shortell

(a) RESIDENCE NO. 1725 Harford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Shortell

6 DATE OF BIRTH (month, day, and year): 5/1/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	67	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Shortell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dora Lenon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Shortell
(Address) 1202 Clifford

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER
NOV 4 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Nov 2, 1923, that I last saw him alive on Nov 2, 1923, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Asthenia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract. neck of right femur (duration) yrs. 10 mos. 16 ds.

18 Where was disease contracted if not at place of death? 1725 Harford ave

Did an operation precede death? no Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Sybert, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem — DATE OF BURIAL: 11/5 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O.K. J. S. Collins M. D
Coroner

Apr 3/23

fall down steps

Spec.—1-10-21—M&T—1500 Bks.

D 80506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D 80506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Ewald

(a) RESIDENCE NO. 1600 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Ewald

6 DATE OF BIRTH (month, day, and year): Dec 22 1892

7 AGE: Years 30 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Patrick J. Farren

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Winifred Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Bernard Farren 1600 E. Chase st.

15 Filed NOV 4 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1923, to Oct. 31, 1923, that I last saw her alive on Oct. 31, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): fibroids Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 26-23

Was there an autopsy? No

What test confirmed diagnosis? P.S. and S.

(Signed) J. V. Szczerbicki, M. D.

19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Nov 5th 1923

20 UNDERTAKER: Geo. F. Rust — ADDRESS: 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80507

CERTIFICATE OF DEATH.

44 ✓

D 80507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1213 Hull St. ST., 24 WARD)

2-FULL NAME Ethel Mary Dudley

(a) RESIDENCE NO. 1213 Hull St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 20 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W. Dudley

6 DATE OF BIRTH (month, day, and year) Jan. 22 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George H. Nixon

11 BIRTHPLACE OF FATHER (city or town) Eng. (State or country)

12 MAIDEN NAME OF MOTHER Harriet Cooper

13 BIRTHPLACE OF MOTHER (city or town) Eng. (State or country)

14 Informant Mrs. Nixon (Address) 1213 Hull St.

15 Filed ..... 19 ..... Registrar

NOV 4 1923 ROBERT R. KRAUTH Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from September 18th 1923, to Nov. 2nd 1923, that I last saw h.. alive on Nov. 1st 1923, and that death occurred, on the date stated above, at 11 4 m.

The CAUSE OF DEATH* was as follows:

Cancer of cervix (Carcinoma)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 4th 1923

Was there an autopsy? No

What test confirmed diagnosis? Exploratory incision

(Signed) Jennie L. Brown, M. D.

Nov 3rd 1923 (Address) 1223 St Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 11/5 1923

20 UNDERTAKER J. Fenn McCully

ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80508

CERTIFICATE OF DEATH.

164 D 80508

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 Cumberland ST. 15 WARD)

2-FULL NAME Henry Dekmidmiller

(a) RESIDENCE NO. 710 Cumberland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wht	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Leichtman

6 DATE OF BIRTH (month, day, and year) June 4-1828

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	95	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Old Stile Rd. Mail

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Ger
(State or country)

14 Informant Mrs Kate Miller
(Address) 710 Cumberland St

15 Filed NOV 4 - 1923, 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July ....., 19..., to Nov 2 ....., 19 23.

that I last saw h alive on Nov 1 ....., 19 23.

and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Old age, and gradual
Marasmus

(duration) yrs. 4 mos ....., ds.

CONTRIBUTORY (Secondary) Inability to take nourishment

(duration) yrs. - mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

11-3-1923 (Address) 1008 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Nov: 5. 1923

20 UNDERTAKER Chas W. Dill — ADDRESS 3109 Fredk: Ave:

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80509 — 90 — D 80509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 8 WARD)

2-FULL NAME Anton William Fetting.

(a) RESIDENCE NO. 1517 N Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret C. Roney

6 DATE OF BIRTH (month, day, and year): Oct. 18, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturing Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: John G. Fetting

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Kate Wheatley

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Maryland

14 Informant: Mrs. Margaret C. Fetting
(Address): 1517 N. Bond St.

15 Filed NOV 4 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923 to Nov 2, 1923,

that I last saw him alive on Nov 2, 1923,

and that death occurred, on the date stated above, at 10:08 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pneumococcic Meningitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) C. Schumann, M. D.

19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: 11/6 19 23

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80510

CERTIFICATE OF DEATH.

90 D 80510

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 Cole ..... St. 19 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME, Kunegunda Stein

(a) Residence No. 1519 Cole ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of—Henry Stein

6-DATE OF BIRTH (month, day and year) Oct 25 1874

7-AGE. 49 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany
(State or Country).

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country).

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Germany
(State or Country).

14- (Informant) Mr Henry Stein

(Address) 1519 Cole St

15- NOV 4 - 1923 Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 2-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 ..... 19 23 to Nov. 2 ..... 19 23

that I last saw h.. alive on Nov. 2 ..... 19 23

and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. S. Haus M. D.

11.3., 19 23 (Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem	Nov. 5 th, 1923
20-UNDERTAKER. John C. Bowman & Son	ADDRESS. 1 E Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Fichtner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80511

CERTIFICATE OF DEATH.

74-001

D 80511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 47 Powell ave (ST.) Rosedale (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Fichtner

(a) RESIDENCE No. 1813 E Patterson Park ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 64 — Months — Days — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cumberland md.

12 MAIDEN NAME OF MOTHER Jennie McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cumberland md

14 Informant: Mrs Hoock

(Address) 1813 E Patterson Ave

15 NOV 4 - 1923 Filed ..... 19 ..... ROBERT R. KNAPP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 25th, 1923, to Nov 1st, 1923, that I last saw h... alive on Nov 1st, 1923, and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Distribution of paralysis

(Signed) Edwin H Bernard, M.D.

Nov 2 1923 (Address) Aberdeen Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov. 6 1923

20 UNDERTAKER: Robt J Turner & Sons — ADDRESS: 1642 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80512

CERTIFICATE OF DEATH.

74-001 ✓

D 80512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 19 Rosemont Ave (ST.) 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin M Talbott

(a) RESIDENCE NO. 19 Rosemont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Margaret A Talbott.

6 DATE OF BIRTH (month, day, and year) Apr 24, 1862

7 AGE: Years 61; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles M. Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Eugene Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Lesley Talbott

(Address): 19 Rosemont Ave

15 Filed NOV 4 - 1923, 19 ..... ROBERT A. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923, to Nov 1, 1923, that I last saw him alive on Nov 1, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senescence

(duration) ..... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G. Webster, M. D.

, 19 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Nov 5, 1923

20 UNDERTAKER: Wm Cook Sons & Frazier — ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D 80513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80513

CERTIFICATE OF DEATH.

40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1068 Vine ST., 18 WARD)

2-FULL NAME Wilmer Denton

(a) RESIDENCE NO. 1068 Vine ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col'd	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Denton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary Denton

(Address) 1068 Vine St

15 Filed NOV 4 1925 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 19 25

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1925, to Nov 2, 1925,

that I last saw h... alive on Nov, 1925

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Rupture Bladder

Peritonitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

, 19 (Address) 939 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Nov 5 1925

20 UNDERTAKER Brown Friedman & Schroder ADDRESS 1140

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Staphylococcus Infection

Cor.—1-12-23—M&T—100 Bks.

D 80514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 80514

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

2-FULL NAME Mary Esther Blake

(a) RESIDENCE NO 110 N. Sschroeder ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Jan 8/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Shirley Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucy Blake
(Address) 110 N. Schroeder St.

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquory (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Miliary Tuberculosis

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Dallam, M. D.
(Coroner)

Nov 3, 1920 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 4 1923
20 UNDERTAKER Brown & Freeland	ADDRESS 1140 Schroeder

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80515

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. Merville Ave (Mt Washington) St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Walker T. Sutton.....

(a) Residence No..... Merville Ave (Mt Washington) St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Sutton

6-DATE OF BIRTH (month, day and year) Feb. 17"1876

7-AGE.	If LESS than 1 day.
47 yrs. 8 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Travelling

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). West Virginia

PARENTS.

10-NAME OF FATHER. John Sutton

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). West Va.

12-MAIDEN NAME OF MOTHER. Sabria A. Monroe

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). West Va.

14- (Informant). W. A. Batten

(Address). Clarksburg West Va

15- Filed NOV 4 - 1923, 19.. Registrar. ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) November 3" 1923

17- I HEREBY CERTIFY, That I attended deceased from October 17th, 1923, to November 3rd, 1923, that I last saw him alive on November 3rd, 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Reuben F. Stillman, M. D.

11/4, 1923 (Address) 6 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Clarksburg, W. Va. DATE OF BURIAL. Nov 4th, 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Eutaw St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80516

CERTIFICATE OF DEATH.

73

D 80516

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 142 N. Monroe St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lena Steward

(a) Residence No. 142 N. Monroe St. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 27 1878

7-AGE,	If LESS than 1 day,
45 yrs. 1 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Operator

(b) General nature of industry, business, or establishment in which employed (or employer)..... Hat Factory

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Kent County.....
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Steward

11-BIRTHPLACE OF FATHER (city or town)..... Kent County
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Emily J. Ford

13-BIRTHPLACE OF MOTHER (city or town)..... Kent County
(State or Country), Maryland

14- (Informant)..... Mrs. M. V. Sorden

(Address)..... 142 N. Monroe St.

15- Filed..... 19..... Registrar.

NOV 4 1923 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from Apr. 1922, 19..... to Nov. 2, 19 23

that I last saw h... alive on Nov. 2, 19 23

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Sporatic Spinal Paraplegia.

(Duration) 1 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Nephritis & Toxaemia

(Duration) 0 yrs. 2 mos. 0 ds.

18-Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Robt. A. Brown M. D.

11-3, 19 23 (Address) 119 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St. Paul's Church Yard Kent Co. Md.	Nov. 5, 1923

20-UNDERTAKER,	ADDRESS
Joseph B. Cook	1003 N. Bolton St

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80517 123 D 80517

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles H. George.....

(a) Residence No... 225 McCurley St. St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie E. George

6-DATE OF BIRTH (month, day and year) July 18, 1874

7-AGE, 49 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, William C. George

11-BIRTHPLACE OF FATHER (city or town)..... Baltimore
(State or Country)..... Maryland

12-MAIDEN NAME OF MOTHER, Ella M. Thompson

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country)..... Maryland

14- (Informant)..... John H. George

(Address)..... 3915 Roland Ave.

15- Filed..... 19.....

NOV 4 1923 ROBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from 10/31/23, 19....., to 11/1/23, 19.....

that I last saw h.m alive on 11/1/23, 19.....,

and that death occurred, on the date stated above, at 3.50 A.m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Pancreatitis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 10/31/23

Was there an autopsy? no

What test confirmed diagnosis? Operative Findings

(Signed) H.U. Harper, M. D.

11-1, 1923 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL, Nov. 5th, 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Bolton St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Operation revealed - omentum plastered over abdomen as if perforation had occurred. Both attempts at removal caused great bleeding - so on account of pts condition no more was done. About 10 small gall stones were removed from hepatic duct. Omentum showed many hemorrhagic spots & followed suit.

Cor.—1-12-23—M&T—100 Bks.

D 80518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80518

CERTIFICATE OF DEATH.

203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cedonia Hosp ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion A. Cole

(a) RESIDENCE NO 518 N. Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25, 1854

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) (J. R. Aldwin Builder)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah A. Collins
(Address) 2015 Eager St.

15 Filed ....., 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of liver

accidental falling of brick wall under construction (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Nov. 2, 1923 (Address) 2102 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	11/5 192
20 UNDERTAKER Gordon & Perkins	ADDRESS Eager

INSTRUCTIONS: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80519

CERTIFICATE OF DEATH.

170 D 80519

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1756 Homestead St. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Webber

(a) RESIDENCE NO 1756 Homestead St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Webber

6 DATE OF BIRTH (month, day, and year): April 1/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paper-hanger
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph Webber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Begnel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Herbert Webber
(Address): 1756 Homestead St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide-Pistol shot in right temporal region, ant-sup Attach- of Lobe of ear.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S A Roller (Coroner.), M. D.

Nov 4/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 11/3 192 3

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS: 1739 Eager

REPLAINLY, WITH ... AGE should be stated EXACTLY. ... should be carefully supplied. AGE should be stated ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks. 80520 Jarret Hall.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80520 + 1-60 D 80520

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Josephs Hosp ST., 9 WARD)

2-FULL NAME Jarret Hall

(a) RESIDENCE NO. White Hall Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Madona & Shawsville

9 BIRTHPLACE (city or town) (State or country) Harford Co

PARENTS
10 NAME OF FATHER William T Hall
11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md
12 MAIDEN NAME OF MOTHER Virginia Jones
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Wm T Hall (Father)
(Address) R D White Hall Md

15 Filed NOV 5 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Nov 4, 1923,
that I last saw him alive on Nov 4, 1923,
and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Syphilis (Clinically).
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No.
Did an operation precede death? ..... Date of .....
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) J W Schmuck M. D.
, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Church — DATE OF BURIAL Nov 6 1923

20 UNDERTAKER E G Kurtz & Son — ADDRESS Forrestown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks. 805'21

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80521 D 80521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carter Dierckson

(a) RESIDENCE NO. Bel Air, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	4	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician Student

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer Md. University.

9 BIRTHPLACE (city or town) (State or country) Bel Air, Md.

PARENTS

10 NAME OF FATHER Wm Lee Dierckson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Cecil County, Md.

12 MAIDEN NAME OF MOTHER Emma Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bel Air Maryland.

14 Informant Mrs Emma Dierckson (Address) Bel Air, Md.

15 Filed NOV 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26 . 1923 . to Nov. 4 . 1923 . that I last saw him alive on Nov. 4 . 1923 , and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Spindle Cell Osteo-Sarcoma of Fibula with Metastases to Inguinal glands, and later Metastases to Lungs.

(duration) yrs. 11 mos (2) ds.

CONTRIBUTORY (Secondary) Carcinomatosis of Lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? Yes Date of Aug 25, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray; Microscopic Examination

(Signed) Geo Young Miller, M. D.

. 19 (Address) 11 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Churchville Harford Co. DATE OF BURIAL 11-4 1923

20 UNDERTAKER H. W. Perkins & Sons Co ADDRESS Mitchell & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80522

CERTIFICATE OF DEATH.

74-001

D 80522

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 805 Arlington Ave ST.: Grange WARD) 21

2-FULL NAME Henry Quenton Werner

(a) RESIDENCE. NO. 805 Arlington Ave ST. Same WARD 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Werner

6 DATE OF BIRTH (month, day, and year) Oct 13 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - collector

(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake Brewing Co

(c) Name of employer Not employed

9 BIRTHPLACE (city or town) (State or country) Mainz Germany

PARENTS

10 NAME OF FATHER Lorenz Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER - Unknown -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant - Mrs E M. Bossle

(Address) 805 Arlington Ave

15 Filed ..... 19..... Registrar

NOV 5 - 1923 ROBERT N. [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov 1923,

that I last saw him alive on " " , 19 ,

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) - Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? - Clinical

(Signed) W W Wheatley, M. D.

, 19 (Address) 4709 York Rd -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov. 5 1923

20 UNDERTAKER Martin Kelley Son ADDRESS 1827 N North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80523

CERTIFICATE OF DEATH.

74-006 80523

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N. Chapel ST., 6 WARD)

2-FULL NAME Katie Pinkett

(a) RESIDENCE NO. 136 N. Chapel ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Henry Pinkett

6 DATE OF BIRTH (month, day, and year): mar 17 1871

7 AGE — Years: 52 | Months: 7 | Days: — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Henry Parker
11 BIRTHPLACE OF FATHER (city or town) (State or country): not known
12 MAIDEN NAME OF MOTHER: Mary Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles H Pinkett
(Address): 136 N. Chapel St

15 Filed ..... 19 ..... Registrar
NOV 5 - 1923 ROBERT P. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): nov 1 / 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 / 1923 to Nov 1 / 1923.
that I last saw h.er alive on Nov 1 / 1923.
and that death occurred, on the date stated above, at 9 00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 2 hours — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) — yrs. — mos. 1 hour — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) O. P. Rocker M. D.
19 (Address) 1804 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: at Burr cemetery — DATE OF BURIAL: nov 5 1923

20 UNDERTAKER: Edward Bryson — ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80524

CERTIFICATE OF DEATH.

21

D 80524

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2923 Eiza ST., 16 WARD)

2-FULL NAME John A. Thiel Jr

(a) RESIDENCE NO. 2923 Eiza ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) July 30 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	15	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, md

PARENTS

10 NAME OF FATHER John A. Thiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Ella Tydings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) John A. Thiel 2923 Eiza Ave

15 Filed ..... 19 ..... Registrar

NOV 5 - 1923 ROSCOE C. KRANTZ Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1923.

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov 2, 1923, that I last saw him alive on Nov 2, 1923, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Abscess and Septicemia

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Incision of Abscess Date of Nov 1-1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) John A. Thiel M.D.

Nov 4, 19 23 (Address) 1219 Cathedral Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 5 1923

20 UNDERTAKER E. L. Fanning & Son 1738 E. Lafayette

ADDRESS Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80525

CERTIFICATE OF DEATH.

D 80525

REGISTERED NO. 74-00 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Vickers Rd. Forest Park ST., WARD)

2-FULL NAME George W. Andrews.

(a) RESIDENCE No. 3210 Vickers Rd., Forest Pk. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Hessler Andrews

6 DATE OF BIRTH (month, day, and year) 6/21/1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	67	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad engineer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O.

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Laurel, Md.

PARENTS

10 NAME OF FATHER William E.

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Margaret Sibley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Jno. T. Andrews.

(Address) 2900 Windsor Ave., City.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 16" , 1923 , to Nov 2" , 1923 ,

that I last saw him alive on Nov 2" , 1923 ,

and that death occurred, on the date stated above, at 7. P m.

The CAUSE OF DEATH* was as follows:

Hemophilegia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Herbert E. Zapp , M. D.

Nov 3. 1923 (Address) 3048 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery, 11/5/1923	19

20 UNDERTAKER	ADDRESS
John C. Mitchell, 1201 W.	Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80526 HEALTH DEPARTMENT—CITY OF BALTIMORE 16

D 80526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 542 N. Carrollton ST. 18 WARD) Swain REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Henrietta Swain

(a) RESIDENCE. No. 542 N Carrollton ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Swain

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Capt Richard Bennet

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Tamzine Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Frances R. Crowell
(Address) 542 N Carrollton Ave

15 Filed . 19 Registrar

NOV 3 - 1923 ROBERT N. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 . 1919 . to Nov 2 . 1923 . that I last saw her alive on Nov Oct 31 1923 . and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Hooper M. D.

11-3 . 1923 (Address) 3462 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Nov. 5 1923
20 UNDERTAKER	ADDRESS
John A. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 80527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 180 Falls Rd ST. 12 WARD)

2-FULL NAME Charles N. Green

(a) RESIDENCE NO. 180 Falls Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Bessie Green

6 DATE OF BIRTH (month, day, and year): Sept 4-1876

7 AGE: Years 47 Months 1 Days 27 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bessie Adams Green (Address) 180 Falls Rd

15 Filed .... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1923, to Nov 1, 1923

that I last saw h alive on Nov 1, 1923

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) .... yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) .... yrs. .... mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinically & Symptoms

(Signed) Jno. H. Finch M. D.

1923 (Address) 717 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon

DATE OF BURIAL: Nov 5 1923

20 UNDERTAKER: Paul T Ramsey

ADDRESS: N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED

ROBERT R. KRAUTER

NOV 5 1923

Burial Permit

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80528

CERTIFICATE OF DEATH.

179 D 80528

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1408 Druid Hill Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard G. Addison

(a) RESIDENCE. No. 1408 Druid Hill Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Addison

6 DATE OF BIRTH (month, day, and year) Jan. 17 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alto Md.

PARENTS

10 NAME OF FATHER Edmond Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alto Md

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mabel Addison (Address) 1408 D Hill Av

15 Filed NOV 5 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov 1, 1923.

That I last saw h[illegible] alive on Nov 1, 1923.

And that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Anasarca

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. DeStruglus M. D.

(Address) 1413 D Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt Lookout Cem — DATE OF BURIAL: 11/6 23

20 UNDERTAKER: Samuel Hamsley — ADDRESS: 848 Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80529

CERTIFICATE OF DEATH.

49 V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 Gough ST., V WARD)

2-FULL NAME John Hagel

(a) RESIDENCE NO. 2031 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~: Frieda Hagel

6 DATE OF BIRTH (month, day, and year): Jan 5/66

7 AGE — Years: 57 — Months: 9 — Days: 26 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon Kpr

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Hagel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frieda Hagel
(Address): 2031 Gough St.

15 Filed NOV 5 - 1923 ROSE K. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to Nov 1, 1923, that I last saw h[illegible] alive on Oct. 31, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Laryngeal)

(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes Laboratory test

What test confirmed diagnosis?

(Signed) Leo Heller, M. D.

11-3-1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — DATE OF BURIAL: Nov 5 1923

20 UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans St.

Spec.—1-10-21—M&T—1500 Blks.

D 80530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80530

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Logue Hutchison (Hutchinson)

(a) RESIDENCE NO. 808 E. Pratt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 20/89

7 AGE: Years 34 Months — Days 12 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Trenton N.J.

PARENTS

10 NAME OF FATHER: Wm Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.J.

12 MAIDEN NAME OF MOTHER: Mary Bullock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.J.

14 Informant: Municipal Hospital Records.

(Address)

15 Filed NOV 5 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from November 2, 1923, to November 2, 1923,

that I last saw him alive on November 2, 1923,

and that death occurred, on the date stated above, at 11:00 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Acute Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude A Nace, M. D.

11/3/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Nov. 5 1923

20 UNDERTAKER: Philip Stering

ADDRESS 212 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. (See Letter file 2-16-25 Signed by S. Levy M.D.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80531 — CERTIFICATE OF DEATH. — 47 D 80531

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 1 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena ~~Sarah~~ Goldstein

(a) RESIDENCE NO. 2224 E. Lombard ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Goldstein

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 44 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Esther Abramson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 Eutaw St

15 Filed NOV 5 - 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/4/23, 1923, to 11/4, 1923, that I last saw h[er] alive on Sunday Nov 4, 1923, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Cancer. (Primary Breast?)

? (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary). Pyelitis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes (Removal of Breast for Cancer) Date of 10/25/23

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidore L. Levy M. D.

11/5, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: 11/5 1923

20 UNDERTAKER: Jack Lewis 1439 E Eutaw St — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 80532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 2 WARD)

2-FULL NAME Helen ~~Hattie~~ Thompson

(a) RESIDENCE NO. 601 E. Broadway WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Sr. R. A. Thompson

6 DATE OF BIRTH (month, day, and year) ? 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	++	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse (at)

(b) General nature of industry, business, or establishment in which employed (or employer): +

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nathan Gousach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Record (Address): Johns Hopkins Hosp.

15 Filed NOV 5 1923 ROBERT N. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Nov 3, 1923,

that I last saw her alive on Nov 2, 1923

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hannon, M. D.

11/4, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mechanicsville. Md.	Nov 6 1923

20 UNDERTAKER: Wm Cook & Co. ADDRESS: 926 North.

80533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C..... 80533

1-PLACE OF DEATH

City of BALTIMORE: (No. 33 E. Cheslud Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice M. Jackson

(Residence in Baltimore: No. 700 E. 35 St St.; yrs. 20 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: May (Month) 26 (Day) 1856 (Year)

7-AGE: 67 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Mechanicsville Md.

PARENTS:

10-NAME OF FATHER: John Mullen

11-BIRTHPLACE OF FATHER, (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Brayley

(Address) 700 E. 35th St

15- Filed NOV 5 - 1923 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D. (Coroner.)

Nov 4 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Franklinville, Md

DATE OF BURIAL: Nov 5 1923

20-UNDERTAKER: Wm Cook

ADDRESS 502 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

D 80534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80534

CERTIFICATE OF DEATH.

6 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

2-FULL NAME William Frosberg

(a) RESIDENCE NO. 437 N. Washington st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Frosberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Reither

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address) M. T. H.

15 Filed NOV 5 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1923, to Nov. 3, 1923,

that I last saw him alive on Nov. 3, 1923,

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Indefinite (Dr. Lally)

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

11-3-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov 6 1923

20 UNDERTAKER John Elliott

ADDRESS 2004 Eutaw

ROBERT N. CARTER Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 80535

REGISTERED NO.

1-PLACE OF DEATH 1242

CITY OF BALTIMORE: (No. ~~1444~~ Hull - ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Welsh

(a) RESIDENCE No. 1242 ~~1444~~ Hull ST., 24 ~~WARD~~

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) WIFE of: Nour

6 DATE OF BIRTH (month, day, and year): April 10th 1874

7 AGE: Years 49 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steerdor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Patrick Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Bridgit Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Saml Donnelly

(Address): 1242 Hull St

15 Filed NOV 5 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3 1923 to Nov. 3 1923

that I last saw h alive on Oct 26 1923

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) James P. Cahen Jr M. D.

Nov 3-23 1923 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cathedral

20 UNDERTAKER: Charles L. Harne

DATE OF BURIAL: Tuesday

ADDRESS: 1701 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80536

CERTIFICATE OF DEATH.

100-001

D 80536

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 W. Henrietta St. ST., 22 WARD)

2-FULL NAME Lillian Bostick. (C)

(a) RESIDENCE No 202 W. Henrietta St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of !!!!!!!!!!!!

6 DATE OF BIRTH (month, day, and year) August 21, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-----	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Callie Bostick. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Julia Lyons. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Julia Lyons. (C) mother.
(Address) 202 W. Henrietta St.

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3rd, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)
Nov. 5th, 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 5 1923

20 UNDERTAKER John H. Toadvine — ADDRESS 1132 E. Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80537

CERTIFICATE OF DEATH.

109-002 D 80537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1014 Woodyear ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Alexander

(a) RESIDENCE. NO. 1014 Woodyear ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Cn

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 27 1912

7 AGE — Years: 11 — Months: 7 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hampton North Carolina

12 MAIDEN NAME OF MOTHER: Bettie Jane Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Bettie Jane Alexander 1014 Woodyear

15 Filed . . 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1923 to Nov 3, 1923, that I last saw h. alive on Nov. 2, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chorea - Tonsilitis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

(Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. [illegible]

DATE OF BURIAL: Nov 5 1923

20 UNDERTAKER: Samuel H. Case & Co

ADDRESS: 1400 Mosher

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

80538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3713 Railroad Ave ST., 13 WARD)

2-FULL NAME Amelia Celes LeBon

(a) RESIDENCE NO. 3713 Railroad Ave, ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
63	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Textile weaver 46

(b) General nature of industry, business, or establishment in which employed (or employer): Cotton factory

(c) Name of employer: Mt. Vernon Cotton Duck Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Charles LeBon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Catherine Kahler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma Long
(Address): 3713 Railroad Ave.

15 Filed NOV 5 - 1923, 19__ ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1923, to November 3, 1923,

that I last saw her alive on November 3, 1923

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Myocarditis, Endocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 6 1923

20 UNDERTAKER: R S Marshall — ADDRESS: 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkd.

D 80539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 80539

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 So. Albemarle ST., 3 WARD)

2-FULL NAME Martin Gosperovitz

(a) RESIDENCE NO. 30 So. Albemarle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 15 yrs. ... mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 38		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Adam Usborn
(Address) 30 So. Albemarle St

15 Filed ..... , 192 .....
NOV 5 - 1923
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)
, 192 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 5 1923
20 UNDERTAKER	**ADDRESS**
John Gebliauckas	45 S Paca St

NOTE PLAINLY, WITH CARBON INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 80540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80540

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N. Eden St ST., 5 WARD)

2-FULL NAME John Stewart

(a) RESIDENCE NO. 431 4eq N. Eden St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) " B
(State or country)

14 Informant Thomas Stewart (Cousin)
(Address)

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chronic Nephritis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Patterson, M. D.
(Coroner.)

Nov. 5/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Nov 6/23
20 UNDERTAKER	ADDRESS
Joseph T.H.Rochester	1413 Fetterson St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80541 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80541

CERTIFICATE OF DEATH.

114

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home Chesnut Hill Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Blackwell Claggett

(a) RESIDENCE. No. St. Elizabeths Home Chesnut Hill Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Claggett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn N. Y.

11 Informant Edward Claggett (Address) 303 Myrtle Ave

15 Filed NOV 5 - 1923, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1923, to November 2, 1923, that I last saw him alive on November 2, 1923, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Nov 4, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 6 1923.
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 80542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80542

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Patapsco ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Willey.

(a) RESIDENCE. No. 1625 Patpsco ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the Late Luella Willey.

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76,	8,	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middletown Va.

PARENTS

10 NAME OF FATHER Jacob Willey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middletown Va.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant Robert Willey. (Address) 28 E. Heath St.

15 Filed NOV 5 1923, 19.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from July ..., 1923, to Nov 4, 1923, that I last saw h[im] alive on Nov 4, 1923, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Douglas, M. D.

(Address) 1 Landsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va Nov 7, 1923 — DATE OF BURIAL

20 UNDERTAKER: H. Howard Evans — ADDRESS 1428 E. Chase

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 80543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80543

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Hanover St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Muhl.

(a) RESIDENCE. No. 1733 Hanover ST. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Ella Muhl.

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62,		28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) (House).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Pa.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

11 Informant (Address) Ella Muhl. 1733 Hanover St.

15 Filed . 19 Registrar

ROBERT N. KRAUTER

NOV 5 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov 3, 1923, that I last saw h... alive on Nov 3, 1923, and that death occurred, on the date stated above, at 1 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Instantaneous (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted —, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinically

(Signed) R. H. Compton M. D.

Nov 3, 1923 (Address) 1644 Mass. Ave. N.W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov. 6 1923

20 UNDERTAKER H. Edward Evans ADDRESS 1425 N. Charles St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80544 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 80544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3929 Falls Road) (ST. OR AVE.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Waltrick

(a) RESIDENCE No. 3929 Falls Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Guy W Waltrick

6 DATE OF BIRTH (month, day, and year): April 16 1876

7 AGE: Years 47 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Jacob Gossert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Guy W Waltrick 3929 Falls Road

15 Filed NOV 5 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Nov 4, 1923.

that I last saw her alive on Nov 3, 1923

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

Carcinoma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 2, 23

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory & Clin.

(Signed) Leo Wm Norris M. D.

Nov 5 1923 (Address) 2020 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg Pa DATE OF BURIAL Nov 7 19 23

20 UNDERTAKER: Chenowith & Son ADDRESS 3617 Chestnut Ave

Spec.—1-10-21—M&T—1500 Bks.

D 80545 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 W. Lanvale ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Volz

(a) RESIDENCE NO. 1438 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Volz.

6 DATE OF BIRTH (month, day, and year) Mar. 31, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) (Self)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry C. Noll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Dietrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Minnie L. Volz.

(Address) 1438 W. Lanvale St

15 Filed NOV 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1922, to November 3, 1923, that I last saw h[illegible] alive on November 2, 1923, and that death occurred, on the date stated above, at 4:30p m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Mitral Stenosis

(duration) 1 yrs. 9 mos 20 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual physical Signs.

(Signed) A M Stevenson, M. D.

11/5, 1923 (Address) 2733 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL Nov 6. 1923

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 80546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80546

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2801 Frisby St. ST., 9 WARD)

2-FULL NAME Helen Marie Steinfeldt

(a) RESIDENCE NO. 2801 Frisby St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): May 17th 1891

7 AGE — Years: 32 Months: 5 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Govanstown Md

PARENTS

10 NAME OF FATHER: Charles H. Steinfeldt

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Freedom Pa.

12 MAIDEN NAME OF MOTHER: Margaret M. Calhoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass

14 Informant: Charles Steinfeldt

(Address) 2801 Frisby St.

15 Filed , 19 Registrar

NOV 5 - 1923 ROBERT N. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): November 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1923, to November 3rd/23

that I last saw h[er] alive on Nov. 3rd, 1923,

and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebro-spinal Tuberculosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frank Purgerson M. D.

19 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 6 1923

20 UNDERTAKER: Richard F. Curley — ADDRESS: 1108 Guilford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Charles J. Scharron

D 80547 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80547

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 W. 20 St., 17 Ward)

2-FULL NAME Charles J. Scharron

(Residence in Baltimore: No. 416 W. 20 St; yrs. mos. ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	✓

6-DATE OF BIRTH. June 27th 1860
(Month) (Day) (Year)

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Special Officer
(b) General nature of industry, business, or establishment in which employed (or employer): Crown Cork & C. Co

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Paul J. Scharrer

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Bertram

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert T. Turner Jr.

(Address) 1412 E. Broadway

15-

Filed NOV 5 1923, 192.... Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 3 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, au- topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Morrison M. D.
(Coroner.)

1923 (Address) 3672 Poplar

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Nov. 6th 1923

20-UNDERTAKER.	ADDRESS
Robert T. Turner	1412 E. Broadway

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80548

179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henrietta Savage

(a) Residence No. Preston St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (Write the word.)

5a-If married, widowed, or ~~divorced~~ HUSBAND (or) ~~WIFE~~ of John Savage

6-DATE OF BIRTH (month, day and year) March 1860

7-AGE. 62 yrs. 8 mos. ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cook

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS:

10-NAME OF FATHER. Isaac Stokely.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Mary Ebbers.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Sister Florence

(Address) Preston St.

15-

Filed..... 192.....

Registrar.

Robert P. Harrison,

DEC 5 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-5-23

17- I HEREBY CERTIFY, That I attended deceased from 11/4 1923 to 11-5 1923

that I last saw h. alive on 11-4 1923

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Chr Bright disease

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolf M. D

11/5 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross DATE OF BURIAL. Nov 6 1923

20-UNDERTAKER. H. C. Wiedefeld & Son ADDRESS 914 Fremont Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80549 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80549

CERTIFICATE OF DEATH.

REGISTERED NO. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 Robert ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Colored~~ Baltimore Pingleton

(a) RESIDENCE NO. 750 Robert ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 4 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10		

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bacc. Md

(State or country)

PARENTS

10 NAME OF FATHER Jos Singleton

11 BIRTHPLACE OF FATHER (city or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Palmer

13 BIRTHPLACE OF MOTHER (city or town) Bacc.

(State or country)

14 Informant (Address) 750 Robert St

15 Filed NOV 5 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 19 23, to Oct 4, 19 23, that I last saw h alive on Oct 3, 19 23 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pulm Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norwood M. D.

Nov 5, 19 23 (Address) 737 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Oct 6 1923

20 UNDERTAKER Jno Geo H Hooper ADDRESS 406 W. Conway St

Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D 80550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80550

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Neely

(a) RESIDENCE NO. 1941 Lexington St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred (in) yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Henry Neely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Fannie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant. Municipal Hospital Records.

(Address)

15 Filed NOV 5 1923, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 19 23

17

I HEREBY CERTIFY, That I attended deceased from October 25, 19 23 to November 1, 19 23,

that I last saw him alive on November 1, 19 23,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude G Dean, M. D.

11-5-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1923 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80551

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505-Norman-Av. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Rebecca Williams

(a) RESIDENCE NO. 505-Norman-Av. ST., 20 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 61 yrs. 10 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. A. J. Williams

6 DATE OF BIRTH (month, day, and year) Dec-18-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Calvert Co., Maryland

PARENTS

10 NAME OF FATHER Geo. L. Robertson

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Monnette

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Maryland

14 Informant Mrs. Bertha L. Hammett (daughter)

(Address) 505-Norman-Av., City.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923 to Nov 5, 1923 that I last saw her alive on Nov 3 1923 and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) — yrs. — mos. 1 hour ds.

CONTRIBUTORY (Secondary) Arteriosclerosis — Hypertension (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physicial diagnosis

(Signed) W. W. Mayo — M. D.

11/5, 1923 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WOODLAWN CEMETERY — DATE OF BURIAL: Nov-7- 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (William F. Mowen, Successor) — ADDRESS: 108 W. NORTH AVE.

NOV 5 1923 Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACTITUDE is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80552

CERTIFICATE OF DEATH.

D 80552

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Robert Street ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Shorey Slater

(a) RESIDENCE NO. 305 Robert Street ST., 14 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 86 yrs. 3 mos. 0 ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Y. Slater

6 DATE OF BIRTH (month, day, and year) August-3-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Troy
(State or country) New York

PARENTS

10 NAME OF FATHER Nehemiah B. Shorey

11 BIRTHPLACE OF FATHER (city or town) Fall River
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Ann Chase

13 BIRTHPLACE OF MOTHER (city or town) Fall River
(State or country) Mass.

14 Informant Miss. Alice C. Slater (daughter)
(Address) 305 Robert Street

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1928

17 I HEREBY CERTIFY, That I attended deceased from October, 1923, to Nov 3, 1928,
that I last saw h[illegible] alive on Nov 3, 1928
and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs
Endocarditis

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Colitis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Pleasants M. D.

, 19 (Address) 1601 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Nov-6-28.

20 UNDERTAKER STEWART & MOWEN COMPANY (Successors)

ADDRESS 108 W. NORTH AVE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Plumb

Edward P. Whitehead

Spec.—1-10-21—M&T—1500 Bks.

D 80553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80553

CERTIFICATE OF DEATH.

144

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Brunt ST., 14 WARD)

2-FULL NAME Lela Johnson

(a) RESIDENCE NO. 1916 Brunt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. . mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Allision Johnson

6 DATE OF BIRTH (month, day, and year) Mar. 27, 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
40	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Worked in home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dunkirk, Md.

PARENTS

10 NAME OF FATHER James Young

11 BIRTHPLACE OF FATHER (city or town) Dunkirk (State or country) Md.

12 MAIDEN NAME OF MOTHER Marquett Witner

13 BIRTHPLACE OF MOTHER (city or town) Dunkirk (State or country) Md.

14 Informant Lloyd Johnson (Address) 1916 Brunt st

15 Filed NOV 5 1923, 19 Registrar Robert P. Harrison, Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to Nov. 4, 1923.

that I last saw her alive on Nov 4, 1923.

and that death occurred, on the date stated above, at 8.05 A m.

The CAUSE OF DEATH* was as follows:

Post partum hemorrhage following birth of child.

(duration) 2 hours yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Susanne R. Parsons M. D.

per J. E. Parsons

, 19 (Address) 1702 Westwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Chancy Calvert Co Md

DATE OF BURIAL 11-7 1923

20 UNDERTAKER Daniel Eanford

ADDRESS Pa ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80554

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH 415 E 21st St.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 12 WARD)

2-FULL NAME Josephine G Jenkins

(a) RESIDENCE. No. 415 E 21 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm R. Jenkins.

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Hensky

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant Wm C. Jenkins

(Address) 415 E. 21st St

15 Filed NOV 5 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to Nov. 4, 1923, that I last saw h alive on Nov 8th, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Septicemia (Abscess of Throat)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Epidemicus Carriage

(durution) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Blood Culture

(Signed) V Kan Williams, M. D.

, 19 (Address) 901 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Cemetery, Govans Md

DATE OF BURIAL Nov 6. 1923

20 UNDERTAKER Harry A Wagner

ADDRESS 1531 Aisquith St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 80555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80555

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. OR HOSPITAL) 8 WARD

2-FULL NAME John W. O'Keefe.

(a) RESIDENCE No 1510 N. Durham St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXXXXXX Hattie O'Keefe.

6 DATE OF BIRTH (month, day, and year) March 22, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer, 540
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Interocean Oil Co.

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER John O'Keefe.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Va.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Hattie O'Keefe. (wife)
(Address) 1510 N. Durham St.

15 Filed NOV 5 1923, 192 Robert T. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned about the face and body.
Explosion of gasoline agitator.
Accidental Death.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)

Nov, 5, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Interocean Oil Co. East Brooklyn

Former or usual residence Oct, 31, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood cem. DATE OF BURIAL Nov-6 1923

20 UNDERTAKER Leo F Cook ADDRESS North Harford Ave

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80556

D 80556

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 S Port ST., 1 WARD)

2-FULL NAME Joseph Raczniak Jr

(a) RESIDENCE NO. 805 S Port ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? 19 yrs. 7 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) 1904 Mar 7

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mln.
	19	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bot Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md U.S.A.

PARENTS

10 NAME OF FATHER: Joseph Raczniak Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Sajdak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Joseph Raczniak 805 S Port St

15 Filed ..... 19 ..... Registrar

NOV 5 - 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 4, 1923

that I last saw h alive on Nov 3, 1923

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Strahl, M. D.

, 19 (Address) 815 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem — DATE OF BURIAL: Nov 7 1923

20 UNDERTAKER: Stephen L Malkowski — ADDRESS: 1005 Hanover St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Cor.—1-12-23—M&T—100 Bks.

D 80557

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 ✓ D 80557

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S Paca St. 22 WARD)

2-FULL NAME Salvadora Cerruglia

(a) RESIDENCE NO. 711 S Paca ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Dec. 6-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER G. Cerruglia

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Salvadora

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mr. John Cerruglia
(Address) 721 Stiles

15 Filed NOV 5 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Inhalation (Coal)

(duration) a few hrs. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. K. Greenleaf M. D.
(Coroner.)

11-5 1923 (Address) 10 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Nov 7 1923

20 UNDERTAKER John J. Corman Funeral Home — ADDRESS 901 Hollins

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80558 — 181-00 — D 80558

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S Paca ST. 22 WARD)

2-FULL NAME Michele Cerniglio

(a) RESIDENCE No. 211 S Paca st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer —

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER John Cerniglio

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Mardis

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mr. John Cerniglio
(Address) 727 So. Eutaw Ave

15 Filed NOV 5 1923, 192 ... Registrar
Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhaling Illuminating Gas

(duration) ... yrs. 9 hours mos. ... ds.

CONTRIBUTORY (Secondary) Accident

(duration) ... yrs. ... mos. ... ds.

(Signed) H K [illegible] (Coroner.), M. D.

11-5, 1923 (Address) 117 N Gaudy St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov 7 1923
20 UNDERTAKER	**ADDRESS**
John J. Cowan & Son	901 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16742 D 80559 D 80559

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS H SPITAL

CITY OF BALTIMORE: (No.) ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juanita Nyce

(a) RESIDENCE No. 5204-38th ST ST., WARD Wash. D.C.

(Usual place of abode) Washington D.C. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Simon Nyce

6 DATE OF BIRTH (month, day, and year) March 25?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D.C.

PARENTS

10 NAME OF FATHER David Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Rueks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D.C

14 Informant Records of Hopkins Hospital (Address)

15 Filed NOV 5 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 - 1923, to Nov. 5 1923.

that I last saw her alive on Nov 5 - 1923

and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, streptococcus

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Brain tumor - Endothelioma

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash DC

Did an operation precede death? Yes Date of Nov 2, 23

Was there an autopsy? Yes

What test confirmed diagnosis? Path & Cultures

(Signed) Warfield M Theobald, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL Nov 5 1923

20 UNDERTAKER W. J. Trickner & Sons North Penna ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80560

D 80560

CERTIFICATE OF DEATH.

494

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME George A. Harris

(a) RESIDENCE NO. Elkins West Va, ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? 51 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Gedion Harris

11 BIRTHPLACE OF FATHER (city or town) West Va (State or country)

12 MAIDEN NAME OF MOTHER Rachel Hosforth

13 BIRTHPLACE OF MOTHER (city or town) West Va (State or country)

14 Informant Johns Hopkins Hospital (Address)

15 Filed ..... 19 Records Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 , 1923 , to Nov 5 , 1923 ,

that I last saw him alive on Nov 5 , 1923

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid Gland

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Post Operative Shock

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov 5 '23

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) J. A. Reichert , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkins West Va	Nov 5 1923
20 UNDERTAKER	ADDRESS
Joseph Ahrens	224 Bway

NOV 5 - 1923

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80561 — 118-602 — D 80561

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 N. Lakewood ave (ST.) 6 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma L. Stumpf

(a) RESIDENCE NO. 213 N. Lakewood ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 2

6 DATE OF BIRTH (month, day, and year): Feb 17th 1911

7 AGE — Years: 12 — Months: 8 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Stumpf

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Kath. Stiefenhofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Jno Stumpf 213 N. Lakewood ave

15 Filed ..... 19 ..... Registrar

NOV 6 - 1923 — Robert F. Garrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 19 23.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 19 23, to Nov 3 19 23,

that I last saw her alive on Nov 3 19 23.

and that death occurred, on the date stated above, at 12 m

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. L. Keyser Jr. M. D.

(Address) 1638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 6 1923

20 UNDERTAKER: J. J. Moran — ADDRESS 3000 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80562

CERTIFICATE OF DEATH.

122-001

D 80562

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 217 W Mulberry ST., 1 WARD)

2-FULL NAME Raymond H. Thomas

(a) RESIDENCE No. 217 W Mulberry ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna E. Thomas

6 DATE OF BIRTH (month, day, and year) Oct 8th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Automobiles

(c) Name of employer Howard A. Jench & Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town) Fairhope (State or country) Fredericksburg Va

12 MAIDEN NAME OF MOTHER Vienna Long

13 BIRTHPLACE OF MOTHER (city or town) Littletown (State or country) Pennsylvania

14 Informant Mrs. McKaugh Sister
(Address) 3404 Edmondson Ave

15 Filed ..... 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th 1923 to Nov 2nd 1923

that I last saw him alive on Oct 2nd 1923

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) Six yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Attended M. D.

19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov 6 1923

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Baltimore St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001 D 80563

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 N. Luzerne Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frederick Brechtel

(a) Residence No..... 11 N. Luzerne Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 29 1878

7-AGE. 44 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Foreman

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Tin Decorating Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Brechtel

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barrie Schaefer

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Margaret Jones

(Address) 11 N. Luzerne Ave

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 6 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct - 15 - 1923 to Nov 3 - 1923

that I last saw h— alive on Nov 3 1923

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

General Hemorrhage —

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) General Coma —

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible] M. D.

, 19 (Address) 125 N. Gay

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem	Nov 6 1923
20-UNDERTAKER.	**ADDRESS**
H. Sander Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80564

D 80564

CERTIFICATE OF DEATH.

90

27

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Grindon Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hertel

(a) RESIDENCE No. 16 Grindon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Hertel

6 DATE OF BIRTH (month, day, and year) Jan 26/1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bank Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hertel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mathilda Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edith R. Hertel
(Address) 16 Grindon Ave (Lauraville)

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insuffiency

(Reported Seventeen) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Pacini, M. D.
(Coroner.)

Nov 5 23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md.	Nov 6 192 3
20 UNDERTAKER	ADDRESS
L. Sander Sons	1710 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 80565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80565

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1941 White ST. N WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie M. Dandridge

(a) RESIDENCE NO. 1941 White ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Dandridge

6 DATE OF BIRTH (month, day, and year): January 1886

7 AGE — Years: 37 yrs. — Months: 8 — Days: ? — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Maryland

PARENTS

10 NAME OF FATHER: Philip H. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Maryland

12 MAIDEN NAME OF MOTHER: Annie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Maryland

14 Informant (Address): Annie Lee 1941 White St.

15 Filed ..... 19 Robert F. Harrison, Registrar

NOV 6 - 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from September 22. 1923. to November 2. 1923.

that I last saw her alive on November 2. 1923.

and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

6 weeks, Duration ..... mds.

CONTRIBUTORY (Secondary) Kidney trouble - how much he does not know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory examination

(Signed) Mary Mead Brain, M. D.

. 19 (Address) 901 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 7 1923

20 UNDERTAKER: Mrs Robert F Elliott — ADDRESS 1923 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80566 44 D 80566

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 8 WARD)

2-FULL NAME Grant Rhodes

(a) RESIDENCE No. 1629 E. Chapel St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: Years 53 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jefferson Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Malinda Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Municipal Hospital Records.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 13, 19 23, to November 2, 19 23.

that I last saw h... alive on November 2, 19 23,

and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 7 mos. (Ruling) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude S. Moore M. D.

11-3-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 6 1923

20 UNDERTAKER: Robert F. Hellion — ADDRESS: 1515 McCulloh St

NOV 5 1923 Robert F. Harrison, Burial Permit Clerk

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 80567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80567

CERTIFICATE OF DEATH.

101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 S. Belnord Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hilda Rollins

(a) Residence No. 618 S. Belnord Ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 17, 1923

7-AGE.	If LESS than 1 day.
.....yrs. 7 mos. 11 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country), Raymond St.

PARENTS.

10-NAME OF FATHER, Hilda Emma Rollins

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Hilda Emma Coffenmicht

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country),

14- (Informant) Raymond H. Rollins

(Address) 618 S. Belnord Ave

15-

Filed ..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1923 to Nov. 3, 1923.

that I last saw her alive on Nov. 3, 1923.

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, following operation for empyema of Right Chest

(Duration) ..... yrs. ..... mos. 10 ds

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) ..... yrs. ..... mos. ..... ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 15, 1923

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager M. D.

, 19 (Address) 2627 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Pauls Cem.	Nov. 6 1923
20-UNDERTAKER. Tilly Bros Inc.	ADDRESS 403 N. Mofft.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OVER—1923

Spec.—1-10-21—M&T—1500 Bks.

D 80568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7/4-001

D 80568

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 532 W Mulberry (St.) (17) (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm T Abbott

(a) RESIDENCE NO. 532 W Mulberry St., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara S. Abbott

6 DATE OF BIRTH (month, day, and year) March 5 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	57	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood working

(b) General nature of industry, business, or establishment in which employed (or employer) machine hand

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Clara S. Abbott

(Address) 404 W. Mulberry St.

15 Filed ..... 19 .....

Registrar

NOV 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 5, 1923, that I last saw h[illegible] alive on Nov 5, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. diag

(Signed) R B Kenyon M. D.

11/6, 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bendersville Pa	Nov 7 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Franklin

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80569 90 D 80569

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N Lexington St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Murray

(Residence in Baltimore: No. 627 N Lexington St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day), 1874 (Year)

7-AGE, 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Chestertown Md

PARENTS.

10-NAME OF FATHER, Murray

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emma Palmer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Murray

(Address) Havre de Grace Md

15-

Filed ..... 191.....

Registrar.

Robert P. Harrison, Chief Permit Clerk.

NOV 8 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3rd, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5th 1923, to Oct. 19th 1923, that I saw h[illegible] alive on Oct. 29 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elaine [illegible] M. D.

11-5, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 11-6-23

20-UNDERTAKER, Wm Beasley

ADDRESS [illegible]

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80570

D 80570

CERTIFICATE OF DEATH.

86-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred GORERIA

(a) RESIDENCE NO 733 E. 30th St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Sept 23/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Goreria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Clara Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John Goreria
(Address) 733 E. 30th St.

15 Filed ..., 192 ... Registrar

NOV 6 - 1923

Richard P. Garrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Colitis-(Otitis Media)

(Autopsy at Hospital)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Wallis, M. D.
(Coroner.)

Nov 6/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11/6 1923

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80571

CERTIFICATE OF DEATH.

159-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Bradford ST., 6 WARD)

2-FULL NAME Pauline M Schelsky

(a) RESIDENCE NO. 424 N. Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single ~~25~~ 1923

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 25 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Albert J. Schelsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Maria Bredtschneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: M. Albert J. Schelsky

(Address) 424 N. Bradford St

15 Filed NOV 6 1923 19 Robert P. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 5 1923

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov 5, 1923

that I last saw h[illegible] alive on Nov 4, 1923

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

(Congenital) Heart

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Pending

(Signed) Fred Burgdorf, M. D.

19 (Address) 800 N Bal[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 7 1923

20 UNDERTAKER: Henry Hoerdt (Son) — ADDRESS: 1301 E Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80572

CERTIFICATE OF DEATH.

D 80572

1-PLACE OF DEATH Volunteers of America Hospital

REGISTERED NO. 101-001

CITY OF BALTIMORE: (No. 418 W. Lexington St., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Hubbard

(a) RESIDENCE No. 20 Rope walk Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 5

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	55	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City, Md.

PARENTS

10 NAME OF FATHER John [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Md.

12 MAIDEN NAME OF MOTHER Harriet Gibbs (Gibbs)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. John Q. Hubbard
(Address) 516 N. Hamburg St

15 Filed NOV 6 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) about Knew ds.

CONTRIBUTORY (Secondary) about Knew

(duration) yrs. mos. ds.

(Signed) H. H. Gorsuch, M. D.
(Coroner.)

Nov 6, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Nov. 8' 1923

20 UNDERTAKER Henry Storck Son — ADDRESS 1301 E Eager St

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80573

D 80573

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Jones

(a) RESIDENCE NO. 1116 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C.	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Franklin Square Hospt. (Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-1923

17

I HEREBY CERTIFY, That I attended deceased from 10-30-, 1923, to 11-3-, 1923, that I last saw her alive on 11-3-, 1923 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon.
Omentum & Liver

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P. M. findings

(Signed) M. J. Parr, M. D.

11/5, 1923 (Address) Franklin Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 6 1923
20 UNDERTAKER	ADDRESS
Wm. R. A. Elliott	172 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 6 1923

D 80574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80574

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2438 Buchanan St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Smith

(Residence in Baltimore: No. 2438 Buchanan St. St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH. August 10th 1904
(Month) (Day) (Year)

7-AGE. 19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Martha Ray

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Smith

(Address) 2438 Buchanan St.

15-

Filed NOV 6 - 1923 192.... Registrar.

Robert T. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John H. Morrissey M. D.
(Coroner)

192.... (Address)

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Leslie Manor Va. Maryland Cemetery Va	Nov 7 1923

20-UNDERTAKER.	ADDRESS
Mrs. R.G. Elliott	1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 80575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80575

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 786 W. Saratoga St. ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno. G. McLaughlin

(a) RESIDENCE NO. 786 W Saratoga St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4-1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	8	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gas & Electric Co.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant May Mc Laughlin
(Address) 786 W Saratoga St

15 Filed NOV 6 1923, 192 Richard P. Harrison
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) W R Jarrett, M. D.
(Coroner.)

11-6-, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Nov 8 1923

20 UNDERTAKER John F Denny ADDRESS 115 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80576

CERTIFICATE OF DEATH.

41

D 80576

1-PLACE OF DEATH Church Home and Infirmary.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. N. Broadway ST., 8 WARD)

2-FULL NAME ~~Darley~~, John W. Darley

(a) RESIDENCE NO. 1518 N. Broadway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Harriette Darley

6 DATE OF BIRTH (month, day, and year) Nov 19, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work LAWYER

(b) General nature of industry, business, or establishment in which employed (or employer) PATTENT

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Wesley Darley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Maria Sangston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant WIFE

(Address) 1518 N Broadway

15 Filed ..... , 19 .....

Registrar

NOV 6 1923

Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Nov 4, 1923,

that I last saw him alive on Nov 4, TH, 1923,

and that death occurred, on the date stated above, at 4.20 m.

The CAUSE OF DEATH* was as follows:

INFECTED FOOT.

Streptococcus Cellulitis

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) LYMPHANGITIS

SEPTICAEMIA ? (duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? ~~Ht~~ 1518 N. Broadway

Did an operation precede death? YES Date of Oct. 30. 23

Was there an autopsy? NO

What test confirmed diagnosis? CLINICAL FINDINGS

(Signed) Gaetano Pantaleo, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 7th 1923
20 UNDERTAKER	ADDRESS 2046
Philip Hering	Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80577

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 E. Franklin Ave (Roseburg) ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda K. Dauses

(a) RESIDENCE NO. 30 E. Franklin St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of John A. Dauses

6 DATE OF BIRTH (month, day, and year) Dec 7th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sabastian Doerbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John A. Dauses 30 E. Franklin Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Nov 5, 1923

that I last saw h alive on Nov 5, 1923

and that death occurred, on the date stated above, at 5-10 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Hypertension 3 yrs. 3 mos ds.

(duration)

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) J. Fred Rumsey M. D.

Nov 6, 1923 (Address) 806 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Nov 8 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Aliceanna

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 80578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 80578

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2019 Mc Henry ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Culp.

(a) RESIDENCE NO. 2019 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Va Culp

6 DATE OF BIRTH (month, day, and year) Dec. 2 - 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith helper

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.

(c) Name of employer Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William H Culp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) Kaltenbach (State or country) Baltimore Md

14 Informant Alice Va Culp

(Address) 2019 Mc Henry St

15 Filed NOV 6 1923, 19 Registrar

Richard F. Carroll, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to November 4, 1923.

that I last saw him alive on November 4th, 1923.

and that death occurred, on the date stated above, at 7.53 a. m.

The CAUSE OF DEATH* was as follows:

Giant-cell sarcoma, upper end of right humerus.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Toxemia & exhaustion.

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? Yes. Date of March, 1922.

Was there an autopsy? Partial autopsy.

What test confirmed diagnosis? Microscopical.

(Signed) C. W. S. Rohrer, M. D.

, 19 (Address) 22 Ailsa Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov. 8 1923

20 UNDERTAKER George L. Schmidt — ADDRESS 2101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80573

CERTIFICATE OF DEATH.

90

D 80573

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1319 N. Eden ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E Heron

(a) RESIDENCE NO. 1319 N. Eden ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Alexander Heron

6 DATE OF BIRTH (month, day, and year) Aug 27th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry D Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah J Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mary E Heron 1319 N. Eden st

15 Filed NOV 19 Registrar

NOV 6 1923

(Robert F. Harrison) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29 1923 to Nov 4 1923.

that I last saw her alive on " 3 1923

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH*, was as follows:

Myocardial degeneration

(duration) yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

Nov. 19 (Address) 2301 Manchester Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Nov 11 1923

20 UNDERTAKER George A. Schilling & Sons

ADDRESS 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80580 — 114 D 80580

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital St., 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dean

(a) RESIDENCE NO. 1721 E. 33rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Dean

6 DATE OF BIRTH (month, day, and year) July 3rd 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Market Master

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Frances Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Lillie Dean (Address) 1721 E 33rd st

15 Filed , 19 Registrar

Robert P. Harrison,

Burial Permit Clerk

NOV 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 4 1923 to Nov 5 1923

that I last saw him alive on Nov 5 1923,

and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 4, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) J. Hamilton Wilson M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Nov 8th 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80581

CERTIFICATE OF DEATH.

D 80581

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1807 Dupeland ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Walstrum

(a) RESIDENCE. No. 1807 Dukeland ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Geo. W. Walstrum

6 DATE OF BIRTH (month, day, and year): 3.4.1837.

7 AGE — Years: 86 — Months: 8 — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Fred. Winkelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Susanah Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mrs. Sarah E. Crawford 1807 Dukeland Ste.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11. 6. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10 - 1923. to November 5 - 1923.

that I last saw h... alive on November 5 - 1923.

and that death occurred, on the date stated above, at 8 05 A. m.

The CAUSE OF DEATH* was as follows:

Sudden Heart Failure

Primities of Age.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harlee H. A. Mey M. D.

11/6, 1923. Address 1031 N. Caroline St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	Nov 9 1923
20 UNDERTAKER	ADDRESS
Wm. Cook	501 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE,

D 80582

CERTIFICATE OF DEATH.

90 D 80582

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5015 Elmer Ave St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Temme (TEMME)

(Residence in Baltimore: No. 5015 Elmer Ave St.; — yrs., 1½ mos. — ds.)

WRITE PLAINLY, WITH INK AND DO NOT USE ABBREVIATIONS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov (Month) 16 (Day), 1840 (Year)

7-AGE, 83 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ~~Carpenter~~ Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ferdinand Temme

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorothy Randor

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna Temme

(Address) 5015 Elmer Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1923, to Nov 5 1923, that I saw him alive on ~~Oct~~ Nov 4 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 yrs. ~~mos.~~ ds.

CONTRIBUTORY (Secondary) Senility and Oedema

(Duration) yrs. 6 mos. ds.

(Signed) C. B. Eusor M. D.

11-5, 1923. (Address) 5016 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov 7, 1923

20-UNDERTAKER Wm Cook

ADDRESS 504 E. Fayette St

NOV 6 - 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 ✓ D 80583

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 E. Monument ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Anthony Heatherick

(a) RESIDENCE NO. 2723 Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced, (~~write the~~ word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Oct 7, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm C. Heatherick

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Berbel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Christina Heatherick (Address) 2723 E Monument St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21 , 1923 , to Nov. 1 , 1923 .

that I last saw h is alive on Nov. 1 , 1923

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion .

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Schmit , M. D.

Nov 1 1923 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Nov 1 1923

20 UNDERTAKER Wm Cook & Son — ADDRESS York Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 6 1923 Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80584

D 80584

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Morton

(a) RESIDENCE NO. 5117 Reistertown Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertie Morton

6 DATE OF BIRTH (month, day, and year) Sept 1 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER John W. Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Municipal Hospital Records.

(Address)

15 Filed 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1923, to November 4, 1923, that I last saw h alive on in November 4, 1923, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic Aorta.

Aortic Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude G. Drane, M. D.

19-5, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 8 1923

20 UNDERTAKER William Cook for E Brantley

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80585

CERTIFICATE OF DEATH. X-199

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hospital ST., 22 WARD)

2-FULL NAME Charlotte M Breitenbach

(a) RESIDENCE NO. 1 Hale Thorpe Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas Breitenbach

6 DATE OF BIRTH (month, day, and year) April 21st 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	35	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Alexander Miller

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Bridie Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Chas Breitenbach
(Address) Relay

15 Filed NOV 6 1923 192 Robert P. Harrison. Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Self Induced Abortion

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Infectious

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Blodget, M. D.
(Coroner)

Nov 5th, 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 7 192
20 UNDERTAKER John Fields	ADDRESS 120 N Eutaw st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

NOV 6 - 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80586

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3347 Beach Ave St. 13 WARD)

2-FULL NAME Catherine Stewart

(a) RESIDENCE NO. 3347 Beach Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Jr Stewart

6 DATE OF BIRTH (month, day, and year) June 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER James Keena

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Keena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant James Jr Stewart (Address) 3347 Beach Ave

15 Filed NOV 7 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from August, 1923, to Nov 6, 1923, that I last saw her alive on Nov 6, 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma - intestines metastasis liver

Asthenia - (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray - personal observation

(Signed) Fernando F. Scarlett M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Nov 8 1923

20 UNDERTAKER OHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80587

CERTIFICATE OF DEATH.

D 80587

REGISTERED NO. 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 15 WARD)

2-FULL NAME Herman C. Kreuzer

(a) RESIDENCE NO. 3213 Carlyle Ave ST., WARD New York
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. about ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marjorie Kreuzer Bristor

6 DATE OF BIRTH (month, day, and year) Sept 12-1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Prof. Dancer
(b) General nature of industry, business, or establishment in which employed (or employer) Vaud
(c) Name of employer

9 BIRTHPLACE (city or town) Syracuse N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Herman Kreuzer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Clementine Bauer

13 BIRTHPLACE OF MOTHER (city or town) Syracuse
(State or country)

14 Informant Herman Kreuzer Father
(Address) 304 Court St. Syracuse

15 Filed ..... , 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Nov. Lacerated liver
Shock due to Injury, Struck by auto Crushing, Injuries Skull Fracture (duration) and Cancer Liver yrs. mos. ds.

CONTRIBUTORY (Secondary) None believed (duration) yrs. mos. ds.

(Signed) W. J. Reilly, M. D.
Nov 6, 1923 (Address) (Coroner) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Assumption Cem. Syracuse N.Y.

DATE OF BURIAL Nov 9th 1923

20 UNDERTAKER Lilly and Feiler

ADDRESS 403 S. Howard St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80588

CERTIFICATE OF DEATH.

101-001 D 80588

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15 WARD)

2-FULL NAME August Kopp

(a) RESIDENCE NO. 2124 Ridgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Charles Kopp

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Tina Horn

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed NOV 7 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1923, to 11-5, 1923, that I last saw h- alive on 11-5, 1923, and that death occurred, on the date stated above, at 4.45 8 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude S. Hurst, M. D.

11-6, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Nov. 7 1923.

20 UNDERTAKER Tilly and Zeiler ADDRESS 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80589 — 74-002 — D 80589

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Mt. Royal Ave ST. 14 WARD)

2-FULL NAME Alexander McIlvain

(a) RESIDENCE NO. 1416 Mt Royal Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. --- ds. -- How long in U. S., if of foreign birth? 70 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A Anderson

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. Thirkel Can Co

(b) General nature of industry, business, or establishment in which employed (or employer) ---------- 086

(c) Name of employer ----------

9 BIRTHPLACE (city or town) ---------
(State or country) Ireland

PARENTS

10 NAME OF FATHER do not know

11 BIRTHPLACE OF FATHER (city or town) -------
(State or country) Ireland

12 MAIDEN NAME OF MOTHER do not know

13 BIRTHPLACE OF MOTHER (city or town) -----
(State or country) Ireland

14 Informant A. A. McIlvain
(Address) 1416 Mt Royal Ave

15 Filed NOV 7 1923, 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4th, 19 23, to Nov 5th, 19 23, that I last saw h alive on Nov 5th, 19 23, and that death occurred, on the date stated above, at 407 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

Nov 6, 1923 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Nov 7 19 23

20 UNDERTAKER Henry W Mears & Son — ADDRESS 807 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 80590

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 316 N. Pulaski ST., 20 WARD)

2-FULL NAME John E. Maasch

(a) RESIDENCE NO. 316 N. Pulaski ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emilie B. Betz Maasch

6 DATE OF BIRTH (month, day, and year) Aug 6 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	63	3	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher 013
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Theodore Maasch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Address) Emilie B Maasch 316 N. Pulaski St.

15 Filed NOV 7 1923, 19 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1923, to Nov. 5th, 1923, that I last saw h~~im~~ alive on Nov. 5th, 1923, and that death occurred, on the date stated above, at 630a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj. Kaden, M. D.

, 19 (Address) 2306 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL Nov 8 1923

20 UNDERTAKER John O Mitchell — ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80591

65-601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 19 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Weise

(a) RESIDENCE NO. 1318 W Lexington St WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 21 1922

7 AGE: Years 1 Months 5 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Gustav Weise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Edith Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Silas B. Mills

(Address) 1318 W Lexington St.

15 Filed ....., 19 ..... Registrar

ROBERT P. KRAUTER

Burial Permit Clerk

NOV 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1923, to Nov 5, 1923, that I last saw him alive on Nov 5, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute leukaemia (probably lymphatic) 42 ds.

(duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary) Anaemia Progressive

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examinations

(Signed) H. A. Meech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Nov 7 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80592 D 80592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmond Stein

(a) RESIDENCE NO. 3503 Penna Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 17 ds. How long in U. S., If of foreign birth? yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 20, 1923

7 AGE — Years | 2 Months | 17 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Morris Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Lurje

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) Johns Hopkins Hosp

15 Filed ....., 19 ..... ROBERT R. KRAUTER Registrar

AUG 7 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov 6, 1923, that I last saw him alive on Nov 6, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Intestinal Indigestion

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Conrad Jelkoff, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Intearmel — DATE OF BURIAL 11/7 1923

20 UNDERTAKER Jack Lewis & Sons — ADDRESS Eldkt

Spec.—1-10-21—MAT—1500 Blks.

Audit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80593

CERTIFICATE OF DEATH.

135 D 80593

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST., 5 WARD)

2-FULL NAME Isaac Audit.

(a) RESIDENCE NO. 275 N. Exeter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Audit

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 78 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E. Baltimore St

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar

NOV 7 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/6 1923

17

I HEREBY CERTIFY, That I attended deceased from 10/28, 1923, to 11/6, 1923, that I last saw him alive on 11/6, 1923, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy, Hypertension, Arteriosclerosis (duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor S. Frey, M. D.

Nov. 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 11/7 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80594

D 80594

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 S. Carlton St; ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Hines.

(a) RESIDENCE. NO. 111 S. Carlton St; ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine J. Hines

6 DATE OF BIRTH (month, day, and year) 7/20/61.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	62	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Coal Yard

(b) General nature of industry, business, or establishment in which employed (or employer) Above 040

(c) Name of employer Consolidated Coal Co.

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER James Hines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine J. Hines (Address) 111 S. Carlton St.

15 Filed NOV 7 - 1923 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/23 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1923, 19.... to Nov. 5, 1923, 19....,

that I last saw him alive on Nov. 5, 1923, 19....,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) ---------- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ----------

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. L. Brand, M. D.

11/6/23 19 (Address) 721 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Nov 8 1923
20 UNDERTAKER John J. Toffolo	ADDRESS 1200 W Lombard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80595

CERTIFICATE OF DEATH.

90 D 80595

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 E. Fort Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kelly.

(a) RESIDENCE. NO. 1122 E. Fort Ave. ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of or WIFE of: Margaret A. Kelly.

6 DATE OF BIRTH (month, day, and year) April, 19, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63,	8,	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Construction

(b) General nature of industry, business, or establishment in which employed (or employer): Iron workman.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Peter Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant Margaret Kelly.
(Address) 1122 E. Fort Ave.

15 Filed . . . . . 19 . . . . Registrar

NOV 7 1923 ROBERT R. KRAUSER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1923 to Nov 6 1923 that I last saw h[illegible] alive on Nov 1 1923 and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows: Myocardial Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. F. Hawkins M. D

Nov 1923 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 9 1923

20 UNDERTAKER A. Howard Evans ADDRESS 1425 St Charles St

Spec.—1-10-21—M&T—1500 Bks.

D 80596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80596

CERTIFICATE OF DEATH.

11

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 13 WARD)

2-FULL NAME Ethel McClure.

(a) RESIDENCE NO. 3440 Auchentoroly Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1916

7 AGE — Years: 7 — Months: 0 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER Charles McClure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER Ethel N. Brooks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant Charles McClure
(Address) 3440 Auchentoroly Ter

15 Filed ..... 19 ..... Registrar

NOV 7 1923 ROBERT N. KRAUTER REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to Nov. 5, 1923, that I last saw her alive on Nov. 5, 1923, and that death occurred, on the date stated above, at 12.20 A.m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix; ~~chronic~~ general peritonitis.

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? 344 Auchentoroly Terrace.

Did an operation precede death? Yes. Date of Oct. 22, 1923.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. B. Price M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Nov 19 23

20 UNDERTAKER: W. M. Rountree

ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80597

CERTIFICATE OF DEATH.

90

D 80597

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Back Gen Hosp ST., 11 WARD)

2-FULL NAME Mrs Ella C Slack

(a) RESIDENCE NO. 714 Madison Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Slack

6 DATE OF BIRTH (month, day, and year) Oct 28 31

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Mine gold

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Fellows

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Selby Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant H M Routson

(Address) 2228 N Mth

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1923, to November 4, 1923, that I last saw h ca alive on November 4 1923 and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Cardiac dilatation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Old age

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John Adcomon, M. D.

(Address) 4704 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 7 1923

20 UNDERTAKER H M Routson — ADDRESS 2228 N Mth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80598

CERTIFICATE OF DEATH.

113 D 80593

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 N Castle (St.) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Shultz

(a) RESIDENCE. No. 909 N Castle St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.C.#6 5468

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George F. Shultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Rosenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Shultz
(Address) 909 N Castle St

15 Filed NOV 7 1923 HUMERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11—6 1923

17 I HEREBY CERTIFY, That I attended deceased from 10—25, 1923 to 11—6, 1923 that I last saw h[illegible] alive on 11—6, 1923 and that death occurred, on the date stated above, at 9.9A m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Pending

(Signed) Fred Dunpha, M. D.

19 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 7th 1923
20 UNDERTAKER	ADDRESS
Leo G. Cook	Northern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 80599 — 161-001 — D 80599

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1411 Poplar Grove St.; 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edith Mary Trulove

(Residence in Baltimore: No. 1411 Poplar Grove St.; yrs. mos. 8hrs ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov 6, 1923 (Month) (Day) (Year)

7 AGE: ....yrs. ....mos. ....ds. If LESS than 1 day, 8 hrs. or —min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): 1411 Poplar Grove

PARENTS

10 NAME OF FATHER: Edgar P Trulove

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Ethel Ball

13 BIRTHPLACE OF MOTHER (State or country): City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar P Trulove

(Address) 1411 Poplar Grove

15

Filed NOV 7 - 1923 191 ROBERT R. KRAUTER Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 6, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 2.15 PM 1923 to Nov 6 10.30 AM 1923

that I saw h-e alive on Nov 6 1923

and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 months 2 weeks.

(Duration) ....yrs. ....mos. ....ds

Contributory (SECONDARY)

(Duration) ....yrs. ....mos. ....ds.

(Signed) R L Kuykendall M. D.

Nov 7, 1923 (Address) Winterbrook Apts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Md. DATE OF BURIAL: Nov 7 1923

20 UNDERTAKER: Henry H. Witzke ADDRESS: 1521 W. Lombard St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80600

CERTIFICATE OF DEATH.

1000 D 80600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

2-FULL NAME Catherine Leroe

(a) RESIDENCE NO. 4103 E. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Daniel Newline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

15 Filed NOV 7 1923, 19 ROBERT R. KRA Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 5, 19 23, to November 5, 19 23,

that I last saw her alive on November 5, 19 23,

and that death occurred, on the date stated above, at 3:5 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Terminal) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sol. & Autopsy

(Signed) Claude G. Bruce, M. D.

11/6 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Nov. 8 1923

DATE OF BURIAL

20 UNDERTAKER Woodcock & Son

ADDRESS 502 E. Waltham.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80601

CERTIFICATE OF DEATH.

413

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Cor Lombard & Green ST., S. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fenton Kerr.

(a) RESIDENCE NO. 1031 N. Washington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, (Married), Widowed, or Divorced, (write the word): Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Clarence D Kerr.

6 DATE OF BIRTH (month, day, and year): 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife - 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm Samuels -

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Hospital Records -

15 Filed NOV 7 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6, 1923.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1923, to Nov 6, 1923,

that I last saw her alive on Nov 6, 1923,

and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Staphylococcus Aureus).

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diffuse Carbuncle of Face, (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes - Date of Nov 3, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings + Blood Culture

(Signed) J. T. T. Hundley Jr., M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cem

DATE OF BURIAL: Nov 8 1923

20 UNDERTAKER: Wm Rolle & Son

ADDRESS: 502 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 80602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80602

CERTIFICATE OF DEATH.

5 31

REGISTERED NO. 6206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tubercular Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Wheat

(a) RESIDENCE NO. 829 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 34 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hod Carrier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

0 35

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ely Wheat

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama

12 MAIDEN NAME OF MOTHER: Lizzy Mudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant: Patient

(Address)

15 Filed NOV 7 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3 19 23

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 19 23, to Nov 3, 19 23,

that I last saw him alive on Nov 3, 19 23,

and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Brondho Pneumonia

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Sputum

(Signed) L. A. Lael, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: arbutus cemetary — DATE OF BURIAL: Nov 7 1923

20 UNDERTAKER: Jos. F. H. Rochester — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80603 — 129 — D 80603

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 Brookfield ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Goodman

(a) RESIDENCE. No. 2511 Brookfield ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred self yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Goodman

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55 yrs.	11 mo	13 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 637

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Simon Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Hertz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Isaac Goodman 2511 Brookfield ave.

15 Filed . 19 ROBERT R. KRAUTER, Burial Permit Clerk. NOV 7 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-5- , 1923, to 11-5- , 1923, that I last saw h EV alive on 11-5- , 1923, and that death occurred, on the date stated above, at 11 30 xx P. m.

The CAUSE OF DEATH* was as follows:

Sudden dilatation of heart - Chron. Nephritis

(duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema,

(duration) 1 hour yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. signs.

(Signed) Solomon E. Katz M. D.

, 1923 (Address) 116 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk. Crematory — DATE OF BURIAL: 11/8/23

20 UNDERTAKER: David Sondheim — ADDRESS: 118-120 Royal Ave

(OVER)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80604 D 80604

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Virginia Ave. (Rasheberg) ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Wagner

(a) RESIDENCE NO. Virginia Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 2 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Nov 4/23

7 AGE — Years: | Months: | Days: 2 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jos. W. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Daustell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Jos. W. Wagner, Virginia Ave

15 Filed ..... , 19 ..... Registrar

NOV 7 1923 ROBERT R. KRAUSER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1923 to Nov 6, 1923 that I last saw her alive on Nov 6, 1923 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sensory

(Signed) Fred Stamm Jr., M. D.

, 19 (Address) 800 W Pratt St Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 8 1923

20 UNDERTAKER: Philip Herring — ADDRESS: 3016 Aliceanna

Spec—12-23-21—E.B.R.S.—400 Bks.

80605 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

80605 D

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 E Baltimore St.) St., 3 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Wyman

(a) Residence No. 1101 E Balto St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 14, 1922

7-AGE. 1 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Philip Wyman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Sadie Schwartz

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Maryland

14- (Informant) Philip Wyman

(Address) 1101 E Balto St

15- Filed NOV 7 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 7-1923

17- I HEREBY CERTIFY, That I attended deceased from 11/6 1923 to 11/6 1923

that I last saw him alive on 11/6 1923

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Upper ~~Right~~ + Middle Lobes of Right Lung)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema Cardiac Dilatation

(Duration) yrs. mos. 15 Min

18-Where was disease contracted If not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Maurice Paulson M. D.

11/6. 1923 (Address) 6 S. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Cemetery — DATE OF BURIAL. 11/7 1923

20-UNDERTAKER. Jack Levin — ADDRESS 1429 E Balto St

N. B.—WRITE PLAINLY, with ink. Information required by law should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Windsor Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen B. Manly Sr.

(a) RESIDENCE NO. 2929 Windsor Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Manly

6 DATE OF BIRTH (month, day, and year) Jan 1 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Express Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen A. Manly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Longler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Manly

(Address) 2929 Windsor Ave.

15 Filed NOV 7 1923 ROBERT K. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29 1923 to Nov. 6 1923, that I last saw h[illegible]live on Nov. 4 1923, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Gradual decline and gradually weakness of heart & Respiration

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Senile Symptoms

(Signed) Thos D Phillips M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 11/7/23

20 UNDERTAKER: C.F. Evans & Son — ADDRESS: 118 W. Mt Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80607

CERTIFICATE OF DEATH.

1/13 D 80607

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 E. Eager ST., 10 WARD)

2-FULL NAME Eleanor A. Healy

(a) RESIDENCE NO. 841 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John. L. Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eleanor M Waller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. John L. Healy

(Address) 841 E Eager St

15 Filed NOV 7 1923 ROBERT R. KRANTZ Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 1923, to 11/7, 1923, that I last saw h[er] alive on 11/6 1923, and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolf M. D.

(Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL Nov. 9 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80608

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Etting St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella M. Woods

(a) RESIDENCE. NO. 1803 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James L. Woods

6 DATE OF BIRTH (month, day, and year): May 28-1890

7 AGE: 33 Years 5 Months 8 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John T. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mamie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: James L. Woods
(Address): 1801 Etting St

15 Filed . 19 Registrar

NOV 7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 . 1923 , to Nov 5 , 1923 , that I last saw h alive on Nov 5 , 1923 , and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Acute Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of +

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] , M. D.

, 19 (Address) 2006 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Nov 8 1923

20 UNDERTAKER: George L. A. Gibson — ADDRESS: 1735 Druid Hill Ave

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80609

CERTIFICATE OF DEATH.

188-002

D 80609

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm S. Boyd.

(a) RESIDENCE No. 1014 N. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie T. Boyd

6 DATE OF BIRTH (month, day, and year) Oct 25, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sylvester Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Slade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Lizzie Hyde
(Address) 1525 C. Baltimore St

15 Filed NOV 7 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:*

Ac. Car Accident

Fracture of Skull

(Duration) yrs. mos. 1 hrs.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. 1 hrs.

(Signed) Geo Clinton Blades, M. D.
(Coroner)

Nov 6 23, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Nov 8 192[illegible]

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80610

CERTIFICATE OF DEATH.

90 D 80610

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST., 19 WARD)

2-FULL NAME Maria L. Hamilton

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Loudon Co Va (State or country)

PARENTS

10 NAME OF FATHER James Hamilton

11 BIRTHPLACE OF FATHER (city or town) Loudon Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Loudon Co (State or country) Virginia

14 Informant Mrs J Power

(Address) 1400 W Lexington St

15 Filed ....., 19 ..... Registrar

ROBERT P. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 23, to Nov 5, 19 23, that I last saw h alive on Nov 5, 19 23, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J J Norwood M. D.

Nov 5, 19 (Address) 1537 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Nov 9 19 23

20 UNDERTAKER George Smith — ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80611

101-001 ✓

D 80611

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Mc Donough ST., 7 WARD)

2-FULL NAME Isiah Downing

(a) RESIDENCE NO. 820 Mc Donough ST., WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Downer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Slaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Sarah Downing

(Address) 820 Mc Donough

15 Filed NOV 7 - 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/23 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Nov 3, 1923.

that I last saw him alive on Nov 2, 1923.

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Bayne M D, M. D.

, 19 (Address) 707 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 11/7 1923

20 UNDERTAKER Mar. R. A. Elliott

ADDRESS 1725 Eastland

N. B.—WRITE PLAINLY, WITH ONE FADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80612 HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 80612

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 W. Fayette ST., 14 WARD)

2-FULL NAME Florence M. Morgan.

(a) RESIDENCE No. 1530 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Morgan.

6 DATE OF BIRTH (month, day, and year) May 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	54	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Jacob Nordward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Thomas H. Morgan.
(Address) 2235 E Lexington St.

15 Filed NOV 7 1923 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6. 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29th 1923 to November 6th 1923.

that I last saw her alive on November 5th 1923,

and that death occurred, on the date stated above, at 4:55 A .m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum and intestines

(duration) 7 yrs. 7 mos 7 ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) ..... yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray & clinical diagnosis

(Signed) Harry Kelbel M.D.

11/6, 1923 (Address) 1324 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. DATE OF BURIAL Nov. 8, 1923

20 UNDERTAKER Mr. Wm. F. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80613

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2367 N Arlington Ave 18 WARD)

2-FULL NAME John H. Lewis

(a) RESIDENCE NO. 2367 N Arlington Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	45	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va

(State or country)

PARENTS

10 NAME OF FATHER John H. Lewis

11 BIRTHPLACE OF FATHER (city or town) Gloucester Co Va

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Rosie Bland

(Address) 2367 N. Arlington Ave

15 Filed 1923 . 19 0836 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 26 19 23 to November 5 19 23 that I last saw him alive on November 1 19 23 and that death occurred, on the date stated above, at 7.10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Hamilton M. D.

11/6 1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Robert R. Harrison, Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

32

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Bks.

D 80614 167 39

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80614

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Whitner

(a) RESIDENCE NO. 736 Carrollton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and other informants should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Apr. 30-1923

7 AGE — Years | 5 Months | 1 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sch Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Will Whitner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Marie Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

Robert P. Harrison, Permit Clerk.

NOV 7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to Nov 1, 1923, that I last saw h alive on Nov 1, 1923 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)
Vomiting

(duration) ..... yrs. ..... mos 17 ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) H. H. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

NOV 7 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80615

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Kernigan

(a) RESIDENCE No. 307 N. Exeter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Abt. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records (Address)

15 Filed NOV 7 1923, 19 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-1923

17

I HEREBY CERTIFY, That I attended deceased from 4-27, 1923, to 11-4, 1923,

that I last saw him alive on 11-4, 1923,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic aortitis

aortic insufficiency

(duration) yrs. 7 mos (Est.) ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude G. Dixon, M. D.

11-7, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patricks — DATE OF BURIAL 11/7/1923

20 UNDERTAKER J. J. Dakey & Sons — ADDRESS 1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6 9-19—H. P. Co.—1000 Bks.

D 80616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 80616

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 Homestead ST.: 9 WARD)

2-FULL NAME Mary C. Biswanger

(a) RESIDENCE. No. 1443 Homestead ST., 9 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William F Biswanger

6 DATE OF BIRTH (month, day, and year) April 4th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Fredrick Renn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Stauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elmer J Biswanger

(Address) 1443 Homestead St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7 1923

17 I HEREBY CERTIFY, That I attended deceased from October 1 1923 to November 7 1923, that I last saw her alive on November 6 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

about (duration) one yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. one mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Was no doubt

(Signed) E Young Matthews, M. D.

11-7 1923 (Address) 16 N Goodwich ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 9th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 80617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80617

38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Isaac Sp. Preston 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Brezel

(a) Residence No. Preston & Valley Sts. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 78 about yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Old
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS:
10-NAME OF FATHER: Daniel Brezel
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Nora Leonard
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-
(Informant): Sister Florence
(Address): Preston & Valley

15-
Filed ..... 192. Robert P. Harrison
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 6. 1923

17- I HEREBY CERTIFY, That I attended deceased from 10/8/23 1923 to 11/6 1923
that I last saw h. alive on 11/5 1923
and that death occurred, on the date stated above, at 12.30 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobularis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

..... (Duration) ..... yrs. ..... mos. Old ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D
, 19 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cemetery Towson	Nov 8 19 23
20-UNDERTAKER,	ADDRESS
H. C. Wiedefeld	914 Gunnit Av

Burial Permit Clerk.

N. B.—WHITE PAPER, WHITE INK. Cause of death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *scpticemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Lueticc

Epco—5-19-13—M & T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80618

CERTIFICATE OF DEATH.

10 D 80618

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 W. Lafayette Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Hazel Richardson

(Residence in Baltimore: No. 1613 W. Lafayette Ave St.; 5 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 13 (Month), (Day), 1911 (Year)

7-AGE, 12 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Berlin, Maryland

PARENTS.

10-NAME OF FATHER. Alfred Arnold Richardson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Catherine Tierney

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Catherine Richardson

(Address) 1613 W. Lafayette Ave.

15-

Filed ..... 191.....

Registrar.

OCT-1923 Robert P. Harrison. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1923, to Nov 6 1923, that I saw h e alive on Nov 6 1923, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emil D. Kahn M. D.

Nov 7, 1923 (Address) 710 N. Mount St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem

DATE OF BURIAL, Nov 7, 1923

20-UNDERTAKER Joe D. B. Cook

ADDRESS 1003 N. Bals St

Spec.—1-10-21—M&T—1500 Blks.

D 80619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80619

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 Bank ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter . Rolof

(a) RESIDENCE No. 1925 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	6	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank. Rolof

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Victoria Slatkowski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr Frank. Rolof (Address) 1925 Bank Street

15 Filed NOV 7 1923, 19 ROBERT P. HARRISON, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5 , 19 23 , to Nov. 7 , 19 23 , that I last saw h alive on Nov 5th , 19 23 , and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (laryngeal)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger M. D.

19 (Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy . Rosary — DATE OF BURIAL: Nov. 8 . 1923

20 UNDERTAKER John G. Weber — ADDRESS 1809 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be explicit in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80620 D 80620

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 19 WARD)

2-FULL NAME Anna Crowthers

(a) RESIDENCE NO. 1509 Mulberry St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vernon W. Crowthers

6 DATE OF BIRTH (month, day, and year) Aug 5. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Wells Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Anna M. Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Berry
(Address) 140 Cedar ave Roland Pk.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to Nov. 6, 1923, that I last saw her alive on Nov. 6, 1923 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) John V. Segerbrock M. D.

, 19 . (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov. 9 1923

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St.

Robert F. Garrison,
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICI... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80621

100-001

D 80621

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 21 WARD)

2-FULL NAME Sophie Krampe

(a) RESIDENCE NO. 1024 Warner St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theodore Krampe

6 DATE OF BIRTH (month, day, and year) March 14 — 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... 19 ..... ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to November 6, 1923,

that I last saw h.. alive on November 6, 1923,

and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Hu... M. D.

11-6, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 9/ 1923
20 UNDERTAKER	ADDRESS
Wm Cook & Son E. North Ave	

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D 80622

D 80622

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Klehm

(a) RESIDENCE NO 3005 Fait Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Klehm

6 DATE OF BIRTH (month, day, and year) Feb 2/1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Germany

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Germany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant William Klehm
(Address) 602 S. Patterson Pk.

15 Filed NOV 8 1923 192 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Poisoning-

(Illuminating gas inhalation-accidental (Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 24 hrs.

(Signed) J S H Pattison, M. D. (Coroner.)

Nov 7/23 192 (Address) 5pi E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 9 1923

20 UNDERTAKER N. Vander & Sons — ADDRESS 1710 Fleet St

Health should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80623

CERTIFICATE OF DEATH.

57

D 80623

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 S. Montford Ave St., 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Davis

(a) Residence No. 715 S. Montford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. Every question should be carefully answered. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Davis

6-DATE OF BIRTH (month, day and year): Feb. 29. 1852

7-AGE: 71 yrs. 8 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Cumberland Md.

PARENTS:

10-NAME OF FATHER: Conrad Mauler

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Easter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Cumberland Md.

14- (Informant): John H. Davis

(Address): 715 S. Montford Ave

15- Filed NOV 8 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1923, to Nov. 6 1923

that I last saw ~~he~~ alive on " 6 1923

and that death occurred, on the date stated above, at 11 45 A. M.

The CAUSE OF DEATH* was as follows:

Carbuncle of Back

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Diabetis Mellitis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. S. Neer M. D.

11/7/23 (Address) 408 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Pauls Cem.	Nov 9 1923

20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

D 80624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80624

CERTIFICATE OF DEATH.

MARY S 5 SASK 118 002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Mrs. Mary E. Lack.

(a) RESIDENCE No. 327 E. 25th St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Lack.

6 DATE OF BIRTH (month, day, and year): Oct 8 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 1920

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER: D. H. Rodeche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Waldeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Record (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/6/23. 19

17

I HEREBY CERTIFY, That I attended deceased from 11/2/23, 19 ..., to 11/6/23, 19 .

that I last saw h— alive on 11/6/23, 19 .

and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Strangulated) Umbilical

Hernia.

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11/3/23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) H. W. Bolley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: 11-9 1923

20 UNDERTAKER: Wm. Chas A. G. Rohde

ADDRESS: 600 N Carlington

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 80625

CERTIFICATE OF DEATH.

D 80625

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 Hoffman St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Gaines

(a) Residence No. 327 Hoffman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Richard Gaines

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs R. A. Elliott

(Address) 1925 Ashland Ave

15- Filed NOV 8 1923 Registrar. ROBERT R. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7 23

17- I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923, to Nov 7, 1923 that I last saw her alive on Nov 7, 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Breast)

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Wm Holliday M. D.

11/8, 1923 (Address) 1925 Ashland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 8 1923

20-UNDERTAKER, Mrs R. A. Elliott — ADDRESS 1925 Ashland Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N Pearl ST., 4 WARD)

2-FULL NAME Salvatore P. Caseio

(a) RESIDENCE NO. 310 N. Pearl ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Caseio

6 DATE OF BIRTH (month, day, and year) Dec 15, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 years	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Italy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER McKuoore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Liberto

(Address) 631 W. Saratoga St.

15 Filed . 19 Registrar

NOV 8 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4th, 1923, to Nov. 6th, 1923, that I last saw him alive on Nov. 6, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

- Myocarditis.
(Heart failure)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry M. Lamm M. D.

, 19 (Address) 1732 Callow Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov 9 1923

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hayford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80627

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Ettings St. WARD) 14

2-FULL NAME Edward C. Savage

(a) RESIDENCE NO 2128 Ettings St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Savage

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer

9 BIRTHPLACE (city or town) Portsmouth, Va,
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Helen Savage
(Address) 2128 Ettings St

15 Filed , 192 Registrar

NOV 6 1923 ROBERT R. CARTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) J. T. Hennessey, M. D.
(Coroner)

Nov. 6, 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 11/8/1923

20 UNDERTAKER James H. Deems — ADDRESS 303 Druid Hill Ave

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 80628

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. ST., 11 WARD)

2-FULL NAME Bonnie Morgan

(a) RESIDENCE NO 1030 N. Eutaw ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Latner
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Bonnie Morgan
(Address) 1030 Eutaw St

15 Filed ..... 192 .....
ROBERT N. KRAUTER, Registrar
NOV 8-1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of brain

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Fell down flight of stairs

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Henderson, M. D.
(Coroner)

Nov. 7, 1923 (Address) 720 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death Colonial yrs., mos., 2 ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? 1529 W. Fayette St.

Former or usual residence 1030 Eutaw St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tyler Texas — DATE OF BURIAL Nov 8 1923

20 UNDERTAKER John W Henderson — ADDRESS & Mamaroneck

Cor.—1-12-23—M&T—100 Bks.

If the City buries this body, please have it buried in [illegible] marked.

D 80629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 167-9 80629

REGISTERED NO. over

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General St. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Doe.

(a) RESIDENCE NO 521 S. Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 30	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Do not know.
(b) General nature of indnstry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Do not know.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Police Report.
(Address): Southern District.

15 Filed 2-8-1923, 192 Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 12, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

Dec, 28, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem DATE OF BURIAL: Jan 2 1924

20 UNDERTAKER: Jack Lewis ADDRESS: 1409 E 22d St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

839

D 80630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80630

CERTIFICATE OF DEATH.

1925

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Municipal Hospital St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Rendall

(Residence in Baltimore: No. 2118 Frederick Ave. St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March (Month) 12 (Day) 1854 (Year)

7-AGE. 69 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore City.

9-BIRTHPLACE, (State or Country). Scotland

PARENTS.

10-NAME OF FATHER. James Rendall

11-BIRTHPLACE OF FATHER, (State or Country) Scotland

12-MAIDEN NAME OF MOTHER. Betsy Rendall

13-BIRTHPLACE OF MOTHER, (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Rendall

(Address) 2118 Frederick Ave.

15-

Filed ..... 192..

NOV 8 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH. November (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

3 hrs

(Duration) Yrs. ds.

CONTRIBUTORY (Secondary) Was blind & fell down steps at Bay View

(Duration) Yrs. ds.

(Signed) Thos. B. Foster M. D.
(Coroner.)

11-5 1923 (Address) Cedar & Curtis Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2118 Frederick Av.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	Nov 8 1923
20-UNDERTAKER. Geo. B. Cook	ADDRESS 1013 N. Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80631

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 80631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1309 St. Paul St. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William G. Scott .....

(a) Residence No. 1309 St. Paul St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Rebecca Scott

6-DATE OF BIRTH (month, day and year) June 5, 1849

7-AGE.	If LESS than 1 day,
74 yrs. 5 mos. 2 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER. William G. Scott

11-BIRTHPLACE OF FATHER (city or town)..... Wilmington
(State or Country)..... Delaware

12-MAIDEN NAME OF MOTHER. Eleanor Jeane

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country)..... Maryland

14- (Informant)..... William M. Scott
(Address)..... 3310 Walbrook Ave.

15-
Filed....., 192.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan....., 1923, to date of death
that I last saw h. in alive on Nov. 7th Day of Nov. 1923
and that death occurred, on the date stated above, at 12.55 P.m.
The CAUSE OF DEATH* was as follows:

Death was due
to a gastric carcinoma
of only indefinite duration

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Thurlow Lee Davis, M. D.

11-7-1923 (Address) 824 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	Nov. 10, 1923
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 N. Bals. St.

N. B.—WHERE EARLY, WRITTEN OR PRINTED RECORDS ARE LACKING, THE ITEMS ON THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80632

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Windsor Mill Road nr. Forest Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel L. Childs

(a) Residence No. Windsor Mill Rd. Nr. Forest St., Ave. Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 3 or 4 yrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Childs

6-DATE OF BIRTH (month, day and year) Apr. 6, 1879

7-AGE.	If LESS than 1 day,
44 yrs. 7 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance Agent.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Woodlawn

(State or Country), Maryland

PARENTS.

10-NAME OF FATHER George Summerfield Childs

11-BIRTHPLACE OF FATHER (city or town).....

(State or Country),

12-MAIDEN NAME OF MOTHER, Susan Younger

13-BIRTHPLACE OF MOTHER (city or town) Woodlawn

(State or Country), Maryland

14- (Informant) Mrs. Marion Childs

(Address) Windsor Mill Road nr. Forest Ave.

15- Filed....., 192.... ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 7th, 1923, to Nov 7th, 1923, that I last saw h alive on Nov 7th, 1923, and that death occurred, on the date stated above, at 8.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) .....yrs.....mos. 1 hour ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 7 yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Para Gen

(Signed) A. C. Summerfield M. D.

11-7, 1923 (Address) Liberty Hts. & Hillsdale Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park	Nov. 9, 1923
20-UNDERTAKER.	ADDRESS
Geo. L. B. Cook	1003 N. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 80633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 80633

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1277 N Chester St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Grable

(Residence in Baltimore: No. 1277 N. Chester St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 29th (Day), 1923 (Year)

7-AGE, ...yrs....mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George A. Grable

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Marie Pencil

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George A. Grable

(Address) 1279 N. Chester St

15-

Filed....., 191.....

NOV 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1923, to Nov 8 1923, that I saw ~~him~~ alive on Nov. 8 1923, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured Bowel

(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) H. Hartman M. D.

Nov 8th, 1923 (Address) 1340 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov. 8th, 1923
20-UNDERTAKER	ADDRESS
E. Kelly Norman Son	1039 Pennsylvania Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D 80634 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80634

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1259 Battery Ave ST. 24 WARD)

2-FULL NAME Mrs Louella Alberta Russell

(a) RESIDENCE No. 1259 Battery Ave ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow Edward L. Russell

6 DATE OF BIRTH (month, day, and year): 11 29 1859

7 AGE: Years 63 | Months 11 | Days 7 | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robert B. Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Margaret J. VanPelt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Mamie Hutsler Daughter

(Address) 1259 Battery Ave.

15 Filed. NOV 8 - 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1922, to Nov 6, 1923, that I last saw her alive on 11. 6, 1923, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Heart Dis

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. four mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. F. Burlington, M. D.

11 6 1923 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem

DATE OF BURIAL: 11/9 1923

20 UNDERTAKER: J. Fen McCully

ADDRESS: 130 E Fort

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80635

CERTIFICATE OF DEATH.

44 D 80635

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 E. 41st. St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theophilus D. Roberts

(a) RESIDENCE No. 611 E. 41st. St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Alice Roberts

6 DATE OF BIRTH (month, day, and year) Nov 5th. (1859)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	-	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice President-

(b) General nature of industry, business, or establishment in which employed (or employer) Fleet McGinley Corp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William H. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. D. Dobler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Miss Mary A. Roberts

(Address) 2235 Madison Ave.

15 Filed ..., 19... Registrar

NOV 8 - 1923 ROBERT E. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1923, to Nov 7th, 1923, that I last saw him alive on November 6th, 1923, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(About 3 yrs. ago small growth over sternum, microscopic examination demonstrated cancer, was removed)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. F. Lockwood M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 11/10 1923

20 UNDERTAKER C.F. Evans & Son-118 W. Mt. Royal Ave.

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80636

CERTIFICATE OF DEATH.

90 D 80636

Registered No.....

1-PLACE OF DEATH 2200 E Balt street

City of BALTIMORE: (No. Hebrew Home for Incurable St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Steinman

(a) Residence No. 121 N Broadway St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jacob Steinman

6-DATE OF BIRTH (month, day and year)

7-AGE, 72 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Israel Berger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Sarah Berger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E Balt st

15-

Filed ..... 192.....

Registrar.

NOV 8 1923

Robert F. Barnes, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/8/23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923 to Nov. 7, 1923

that I last saw her alive on Nov 7 1923

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Cortical sclerosis

myocardial insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Lebenstein M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. North Cem. Co. Garmon Mill Rd DATE OF BURIAL. 11/8 1923

20-UNDERTAKER. Jack Levis ADDRESS 1439 E Balt st

N. B.—WHITE PLAINLY, WITH UNFADING INK. ALL QUESTIONS should be answered. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80637

161-001

D 80637

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Riverside Ave ST., 24 WARD)

2-FULL NAME Mary Catherine Irwin

(a) RESIDENCE NO. 1012 Riverside Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 3-1923

7 AGE Years Premature 7th Months Foetal month 6 Days — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Jacob H. Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret L. Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Jacob H. Irwin
(Address) 1012 Riverside Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from 11. 8, 1923, to 11. 8, 1923, that I last saw h[illegible] alive on 11. 8, 1923, and that death occurred, on the date stated above, at 3. a m.

The CAUSE OF DEATH* was as follows:

Premature Birth from
Placenta Praevia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Burlington, M. D.

11.8. 1923 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks Cem. — DATE OF BURIAL Nov. 8 1923

20 UNDERTAKER M. S. Flynn — ADDRESS 1422 Light St.

NOV 8 1923 Robert P. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80638

111-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 945 Walnut St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Smith

(a) Residence No. 945 Walnut St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Smith

6-DATE OF BIRTH (month, day and year) Mar. 16 1883

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)..... General 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) ~~Unknown~~
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

14- (Informant) Mary Smith

(Address) 945 Walnut St.

15- Filed..... 19..... Registrar.

NOV 8 1923

Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 6 23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Nov. 6, 1923

that I last saw him alive on ~~Oct~~ Nov 6 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Ulcer Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Harold Wrayson M. D.

11/6, 1923 (Address) 502 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn — DATE OF BURIAL, Nov. 10, 1923

20-UNDERTAKER, Jos. Farrell — ADDRESS 2314 Linden Ave

NOTICE TO PHYSICIANS AND UNDERTAKERS—This certificate should be carefully prepared. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Hromadnik)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80639

99-002

D 80639

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH 1637 Aliceanna St

CITY OF BALTIMORE: (No. ... ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Hromadnik

(Residence in Baltimore: No. 1637 Aliceanna St. St.; 50 yrs., ... mos. ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F | 4-COLOR OR RACE, W | 5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) W

6-DATE OF BIRTH, not known, ... (Month) (Day) 1844 (Year)

7-AGE, 79 yrs. X mos. X ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hromadnik

(Address) 1637 Aliceanna St.

15-

Filed ..., 191...

Registrar.

Robert E. Harrison, Clerk

NOV 8 1923

Circuit Court No. 1

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1923, to Nov 6 1923, that I saw h. alive on Nov 6 1923 and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. H. Dellworth M. D.

Nov. 6 1923 (Address) 928 N. Carlton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Nov. 9, 1923

20-UNDERTAKER [illegible] | ADDRESS 1906 Orleans

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80640

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 212 North Poppleton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Bruckoch

(a) Residence No. 212 North Poppleton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Roman Bruckoch

6-DATE OF BIRTH (month, day and year): May 7 1844

7-AGE: 79 yrs. 5 mos. 30 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Helen A. Bruckoch

(Address): 212 North Poppleton

15-

Filed, 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 6th 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923 to Nov 6 1923

that I last saw h alive on Nov 6 1923

and that death occurred, on the date stated above, at 630 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Norwood M. D.

Nov 7, 1923 (Address) 939 W Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 9 1923

20-UNDERTAKER: Jos. Weber & Son — ADDRESS: 2503 Edmondson Ave

NOV 8-1923

Burial Permit Clerk.

Robert P. Barrister

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80641 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80641

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 552 St. Mary's Ct St., 17 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Hollins

(a) Residence No. 552 St. Mary's Ct St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1889

7-AGE. 34 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Fanny Mitchell

(Address) 552 St. Mary's Ct

15- Filed NOV 8 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1923 to Nov 6 1923

that I last saw h[illegible] alive on Nov 5 1923

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John C. Casey, M. D.

, 19 (Address) 703 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 11-7-, 19 23

20-UNDERTAKER. David Easton

ADDRESS 916 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Alcoholism

Spec.—1-10-21—M&T—1500 Blks.

D 80642 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lewis

(a) RESIDENCE NO. 805 McKim St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Lewis

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Julia Lewis

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed NOV 6 1923, 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from September 13, 1923, to November 6, 1923,

that I last saw h alive on November 5, 1923,

and that death occurred, on the date stated above, at 3:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude T. Ash, M. D.

11-7, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 11-8, 1923

20 UNDERTAKER Dan'l Easton

ADDRESS 916 Lima ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80643 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80643

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 125 N. Fulton Ave. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Rebecca McCauley

(a) Residence No. 125 N. Fulton Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph M. McCauley

6-DATE OF BIRTH (month, day and year) July 10, 1846

7-AGE: 17 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Ellicott City (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Thomas E. Bush

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Harriet Elizabeth De Minnis

13-BIRTHPLACE OF MOTHER (city or town) Howard County (State or Country), Maryland

14- (Informant) William E. McCauley

(Address) 125 N. Fulton Ave.

15- Filed NOV 8 1923 19 Robert E. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1923 to Nov 7 1923

that I last saw her alive on Nov 7 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mat. O'Neill M. D.

11-7, 23 (Address) 108 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Augustine Church Cem. Elkridge Md

DATE OF BURIAL: Nov. 9 19 23

20-UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 80644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80644

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3110 Pulaski (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Rebecca Todd

(a) RESIDENCE. No. 3110 Pulaski St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Todd

6 DATE OF BIRTH (month, day, and year) ? 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Bartholow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Laura E. Brittain Jr. (Address) 3110 Pulaski St.

15 Filed NOV 8 1923, 19

Robert F. Harrison, Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Nov 7, 1923, that I last saw h[er] alive on Nov 7, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Chas. L. Dr. Kahn, M. D.

11/7, 1923 (Address) 910 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 7 1923
20 UNDERTAKER	ADDRESS 1532 Fulton
Geo. A. Smith	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

B. & O. R. R.

D 80645

HEALTH DEPARTMENT—CITY OF BALTIMORE

Passenger Clerk

D 80645

CERTIFICATE OF DEATH

Mary Gooderum

REGISTERED NO. 25446

Westover W. Va.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Smith

(a) RESIDENCE NO. Weston, W. Va. ST., WARD Weston W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb 21 1882

7 AGE: Years 41 yrs; Months 9; Days 5; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): W. Va. Weston W. Va.

PARENTS

10 NAME OF FATHER: Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Weston W. Va.

12 MAIDEN NAME OF MOTHER: Mary Gaspke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Weston W. Va.

14 Informant: Capt. Thos. Smith

(Address): Weston, W. Va.

15 Filed NOV 8 1923, 19 — Registrar

Robert J. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-8 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1923, to 11-8, 1923.

That I last saw her alive on 11-8, 1923,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary or Coronary Embolus

(duration) yrs. mos 1/2 hr

CONTRIBUTORY (Secondary): Carcinoma of Ovary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10/11/23

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. V. Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Weston West Va — DATE OF BURIAL: Nov 8th 1923

20 UNDERTAKER: F B Heffner — ADDRESS: 223 Lee St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80646

CERTIFICATE OF DEATH.

45

D 80646

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 W. Franklin ST., 70 WARD)

2-FULL NAME Herman H. Wesselman.

(a) RESIDENCE NO. 1834 W. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Wesselman

6 DATE OF BIRTH (month, day, and year) Jan 28 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Wesselman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Wesselman
(Address) 1834 W. Franklin St

15 Filed ..... 19 ..... Registrar

NOV 10 1923 Robert P. Harrison, Health Commissioner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8. 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1923 to Nov 8th 1923 that I last saw h— alive on Nov 8th 1923 and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin Cross, M. D.

(Address) 600 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Nov. 10. 1923

20 UNDERTAKER Thos. Kis. John H. Feutel & Son ADDRESS 501 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80647

D 80647

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Henderson

(a) RESIDENCE NO 1128 N. Calhoun St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Lomack
(Address) 1128 N. Calhoun St.

15 Filed ..... 192 ..... Registrar

10/8 1923 Robert P. Harrison, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis
Mitral Stenosis &Insuffiency

Autopsy at Hospital (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) S. A. Wilson, M. D. (Coroner.)

Nov 8/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL N. H. Farm

DATE OF BURIAL 11/9 192

20 UNDERTAKER James A. Kemp

ADDRESS 300 Gorsuch

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80648

D 80648

CERTIFICATE OF DEATH.

75-00 V V

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 N Lonbard ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Saturn

(Residence in Baltimore: No. 1429 N Lonbard St.; 54 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept. (Month) 4 (Day), 1862 (Year)

7-AGE, 54 yrs. 2 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Matthew Mullaney

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Lean

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine F. A. Burn

(Address) 1632-6th St N. W. Washington

15-

NOV 9 - 1923

Filed ....., 191.....

ROBERT B. KRANTZ, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 8th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1923, to Nov 8th 1923, that I saw her alive on Nov 1st 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion from a Carc. of the Uterus following paralysis

Occurring 6 years ago

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer of the Uterus

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) John A Pennington M. D.

Nov 8th, 1923 (Address) 1826 Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Nov. 10th, 1923

20-UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Hollins Sts.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks No history

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 30649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30649

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument St., 14 WARD)

2-FULL NAME Henry Gundersheimer

(a) RESIDENCE NO. 1716 Eutaw Pl., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Mch 12 1851

7 AGE — Years: 72 — Months: 8 — Days: 25 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Columbus Ohio

PARENTS

10 NAME OF FATHER: Joseph Gundersheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Esther Greenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Edward Likes 1716 Eutaw Place

15 Filed NOV 9 1923, 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 1923, to 11/7, 1923, that I last saw him alive on 11/7, 1923, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema — following Cerebral Haemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidore D. Frey, M. D.

Nov. 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. — DATE OF BURIAL: 11/9/1923

20 UNDERTAKER: David Sondheim — ADDRESS: 118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80650

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 630 N. Carrollton Ave 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emilie Elanore Motz

(a) RESIDENCE. No. 630 N. Carrollton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph F Motz

6 DATE OF BIRTH (month, day, and year) March 9, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. Habbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleanora Pietch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Rudolph Martin 3923 Green Mount Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from 6 Nov . 1923 , to 7 Nov . 1923 , that I last saw her alive on 7 Nov . 1923 , and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Phthisis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) - yrs. - mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Horace W. Byers , M. D.

, 19 (Address) 749 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Nov 10 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80651 49 D 80651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gd. 2554 W. Pratt ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Grimes

(a) RESIDENCE No. 2554 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Belle Mobley

6 DATE OF BIRTH (month, day, and year): July 26 1851

7 AGE — Years: 72 Months: 3 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Officer Police

(b) General nature of industry, business, or establishment in which employed (or employer): 661

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Albert H. Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Bertha M. Heininger

(Address) 2554 W. Pratt St.

15 Filed NOV 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Nov. 6, 1923, that I last saw him alive on Nov. 6, 1923, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat & Neck

(duration) One yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry E. Ohle M. D.

Nov 6 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov. 9 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80652

CERTIFICATE OF DEATH.

190 D 80652

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belair & Valley View Aves. WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Herman

(a) RESIDENCE No. Belair & Neckar Aves ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Herman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nettie Herman
(Address) Belair & Neckar Aves

15 Filed ..... 192 ..... Registrar

NOV 3 - 1923 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Dilatation of Heart
(Died in wagon enroute home)
about (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... mos. ..... ds.

(Signed) Jos. H. Pollens, M. D. (Coroner.)

Nov 9/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Herring Run — DATE OF BURIAL 11/9/23

20 UNDERTAKER Jack Levin — ADDRESS 1298 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D 80653

REGISTERED NO.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 N. Chapel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. R. L. Lynch

(a) RESIDENCE NO. 1624 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Margaret A. Lynch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 058

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Emily Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs Margaret A. Lynch 1624 N. Chapel St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 18 . 1923 . to Nov. 7 . 1923 . that I last saw him alive on Nov 7 . 1923 , and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

11/8 . 1923 (Address) 1820 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 10 1923
20 UNDERTAKER	ADDRESS
Henry Koeck & Son	1301 E. Eager

NOV 9 1923

Robert F. Harrison
Burial Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lethargic

Spec.—1-10-21—M&T—1500 Blks.

D 80654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80654

CERTIFICATE OF DEATH.

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

2-FULL NAME Mrs Catherine Lowe

(a) RESIDENCE NO. Mt Hope Retreat ST., 28 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a ~~Married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Mr Lowe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	76	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Co Mayo Ireland

PARENTS

10 NAME OF FATHER Jeremiah Loftus

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Ireland

12 MAIDEN NAME OF MOTHER Catherine Dreany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Ireland

14 Informant Records of Mt Hope Retreat (Address) Balto Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Nov. 5, 1923, that I last saw her alive on Nov. 5, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

abt (duration) 4 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Depressive Psychosis

abt (duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Nov 12 1923.
20 UNDERTAKER	ADDRESS
Martin Kehoe & Son	827 W North

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30655

99-1 ✓

D 30655

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 17 W Preston St. H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mary Schleigh

(a) RESIDENCE. NO. 17 W Preston St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W hite	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 19/21.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Edward Schleigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary Grimm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Mary Schleigh (Address) 17 W Preston St

15 Filed . 19 Registrar

NOV 9 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1923, to Nov. 8, 1923, that I last saw h er alive on Nov. 7, 1923, and that death occurred, on the date stated above, at 3:40 A.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Marasmus.

(duration) yrs. 2 mos. 2/3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Machin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Nov 9 1923
20 UNDERTAKER	ADDRESS
Martin Drake & Son	1827 W North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 80656 HEALTH DEPARTMENT—CITY OF BALTIMORE 47 D 80656

CERTIFICATE OF DEATH

1-PLACE OF DEATH — CITY OF BALTIMORE: (No.) 6 W. Hamilton Ave ST., Rasteburg WARD) — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Bauer

(a) RESIDENCE NO. 6 W. Hamilton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Richard E. Bauer

6 DATE OF BIRTH (month, day, and year) Dec 24/69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Christian Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Richard E. Bauer (Address) 6 W. Hamilton

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to Nov 6, 1923, that I last saw h[illegible] alive on Nov 6, 1923 and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast (Secondary)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 3 or 4 days ago

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Signed) Caleb N. Athey, M. D.

Nov 8. 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL Nov 9 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80657

89 D 80657

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4406 Maine Ave ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. John Frederick Heisse

(Residence in Baltimore: No. 4406 Maine Ave. - St.; 36 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1862 (Year)

7-AGE, 61 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Minister of the Gospel
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, John F. Heisse

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Rebecca Cuddy.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allen J. Foster

(Address) 4406 Maine Ave.

15-

Filed....., 191.....

Registrar.

NOV 8 - 1923

ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26 1923, to Nov. 8 - 1923, that I saw him alive on Nov 6 - 1923, and that death occurred, on the date stated above, at 3 50 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Suddenly (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cold & general bad. down — (Duration) ....yrs. ....mos. 12 ds.

(Signed) M B Townsend Med M. D.

Nov 8....., 1923 (Address) 426 N. Johnson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Nov. 16....., 1923
20-UNDERTAKER George J. Smith	ADDRESS 552 Hollins st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80658

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 E: Preston St ST., 9 WARD)

2-FULL NAME ..daline O: Strible.

(a) RESIDENCE NO. 1220 E: Preston St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John ..: Strible

6 DATE OF BIRTH (month, day, and year) 7/28/1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	3	10	

8 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Pearl Durkee

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Drew

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mr. Charles Busick
(Address) 1220 E: Preston St

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/1923 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923, to Nov. 7 1923, that I last saw h[illegible] alive on Nov. 6, 1923, and that death occurred, on the date stated above, at 2.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Lee Magness, M. D.

11.8.1923 (Address) 1206 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/10/23

20 UNDERTAKER John Merrick

ADDRESS 208 Orleans St

NOV 9 - 1923 [illegible]

Cor.—1-12-23—M&T—100 Bks.

Wm H Conway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80659 ✓ D 80659

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Pearl st ST., 17 WARD)

2-FULL NAME Wm H. Conway

(a) RESIDENCE NO. 412 Pearl St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 086
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wm H Conway

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Geo Bowyer
(Address) 412 Pearl St

15 Filed ..... 192 .....
Registrar

NOV 9 1923 ROBERT R. KRAUTER
REGISTRAR OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ... yrs. ... mos. ... ds.

(Signed) W K Gonce M. D.
(Coroner)

11-9, 1923 (Address) 113 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11/9 '23
20 UNDERTAKER	ADDRESS
Jas J Hemsley	578 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80660 — 129 — D 80660

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 Vineyard Lane ST., 12 WARD)

2-FULL NAME Samuel T Hollett

(a) RESIDENCE NO. 9 Vineyard Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Martha A Hollett

6 DATE OF BIRTH (month, day, and year) June 15, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Castle (State or country) Del.

PARENTS

10 NAME OF FATHER Benjamin Hollett

11 BIRTHPLACE OF FATHER (city or town) New Castle (State or country) Del.

12 MAIDEN NAME OF MOTHER Groner

13 BIRTHPLACE OF MOTHER (city or town) New Castle (State or country) Del

14 Informant Mrs Emma Mormann

(Address) 9 Vineyard Lane

15 Filed NOV 9 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Distr.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Nov 8, 1923.

that I last saw ~~him~~ alive on Nov 7, 1923

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about One (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

4-8-1923 (Address) 310 Hull

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Hoboe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80661 — D 80661

CERTIFICATE OF DEATH.

31

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 3244 E Baltimore ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Newman

(a) RESIDENCE No. 3244 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov 6 1902

7 AGE — Years: 21 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Banking House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm. J. Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Caroline Schiff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Wm. J. Newman

(Address): 3244 E Baltimore

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov 7, 1923, that I last saw him alive on Nov 7 - 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ac. Mil. T.B.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Ed Carson

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Exam

(Signed) Geo Chew Fow Bladed M. D.

(Address) 1437 N Bway

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 11/10/23

20 UNDERTAKER: John A Moran — ADDRESS: 3000 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

NOV 6 1923 ROBERT R. KRAUTER, Board Member

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80662

CERTIFICATE OF DEATH.

181-001 ✓

D 80662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N. Howard St. 11 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Acelia M. Augustine

(a) RESIDENCE NO 724 N. Howard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	12	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Augustine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14
Informant Margaret Augustine
(Address) 724 N. Howard St.

15
Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

asphyxiation by gas
accidental

(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) (Gas Poisoning)
(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)
Nov. 9, 1923 (Address) 280 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 11/10/ 1923

20 UNDERTAKER J. F. Moran

ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80663

CERTIFICATE OF DEATH.

D 80663

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 220 S. Chester ST., 2 WARD)

2-FULL NAME Philip H. Sherwood

(a) RESIDENCE NO. 220 S. Chester ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 1839

7 AGE — Years: 84 Months: 2 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. City Hall

(b) General nature of industry, business, or establishment in which employed (or employer): Wash D.C.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry H. Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Eliza Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Annie Sherwood
(Address) 220 S. Chester St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Nov 7th, 1923, that I last saw him alive on Nov 6th, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Haemotomyelia
Acute Myelitis
(duration) ... yrs. mos 27 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia
(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Hebbard M. D.

, 19 (Address) 2011 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 11/10/1923

20 UNDERTAKER: J. A. Moran — ADDRESS 3000 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80664

CERTIFICATE OF DEATH.

129 D 80664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Fayette E ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fagan

(a) RESIDENCE. NO. 1535 Fayette st E ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 34 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Chas Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto –

12 MAIDEN NAME OF MOTHER: Rebecca Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto –

14 Informant: Rebecca Fagan
(Address): 1535 Fayette St E

15 Filed . 19 NOV 9 - 1923 Registrar
ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Nov 7, 1923, that I last saw h alive on Nov 5, 1923, and that death occurred, on the date stated above, at 5 07 m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

11/8, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetry

DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: Mrs Chas G. Bailey

ADDRESS: 1421 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80665

CERTIFICATE OF DEATH.

31 D 80665

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 N. Dallas ST., 8 WARD)

2-FULL NAME Loreata Byers

(a) RESIDENCE NO. 1734 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): — 1867

7 AGE: Years 56; Months —; Days —; If LESS than 1 day,... hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife 37

(b) General nature of Industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Henry Frogdom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ellen Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Mother Ellen Frogdom

(Address): 1734 N. Dallas

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, NOV 9 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 6 1923

17 I HEREBY CERTIFY, That I attended deceased from November 3. 1923. to November 6. 1923. that I last saw her alive on November 6. 1923. and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Tuberculosis of Lung (duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?.. no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. A. W. Kennard M. D.

11-6. 1923 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Nov 8 1923

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725 Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80666

CERTIFICATE OF DEATH.

164

D 80666

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret T. Baker

(a) Residence No. Preston & Patterson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ ~~Widowed,~~ Widow or ~~Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Baker

6-DATE OF BIRTH (month, day and year) — 1847

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Old

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Elias Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Jane A. Sims.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Sister Florence

(Address) Preston & Patterson

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/8/23

17- I HEREBY CERTIFY, That I attended deceased from 11/5 1923 to 11/8 1923

that I last saw h. alive on 11/7 1923

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolf M. D

11/9 1923 (Address) 914 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross

DATE OF BURIAL. Nov 10 1923

20-UNDERTAKER. K. C. Widefeld

ADDRESS 904 Greenmount Ave

NOV 9 - 1923 ROBERT R. KRAUTER BURIAL PERMIT CLERK

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—I-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80667

CERTIFICATE OF DEATH.

90 D 80667

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 N Maderia St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin N. Parry

(a) RESIDENCE No 1512 N. Maderia St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Parry

6 DATE OF BIRTH (month, day, and year) Feb 1/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Parry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Annie Parry
(Address) 1512 N Madeira St

15 Filed ..., 192 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Appoplexy or Myocardial Insuffiency

(Found dead in Bed)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Proctor, M. D.
(Coroner.)

Nov 9 23 92 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/10 1923

20 UNDERTAKER Albert L. Hiltz Jr. — ADDRESS 1606 N Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80668

CERTIFICATE OF DEATH.

90

D 80668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Front ST., 5 WARD)

2-FULL NAME Wm Parker (alias) Wm Otty

(a) RESIDENCE NO 100 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years: about 50 Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 087
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Police

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed NOV 9 1923, 192 ROBERT R. KRAUTER Registrar

0847

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Valv. dis Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Nov. 9, 192 3 (Address) 1054 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

D 80669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 80669

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1415 Eastern ave ST. 2d WARD)

2-FULL NAME Wm J. Griffith

(a) RESIDENCE No. 1416 E. Eastern ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55		—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Dept
(Address) Eastern Dist

15 Filed ....., 192 ..... Registrar

0848

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 — 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton, M. D.

Nov 9 — 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80670

CERTIFICATE OF DEATH. No 179

D 80670

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

2-FULL NAME Charles Banks

(a) RESIDENCE NO. Lived in a shack on a dump somewhere in South West Balto — Street unknown

(Usual place of ... (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dept Eastern Dist

15 Filed ..., 192 ... Registrar

0849

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd Degree burns on body & arms

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

, 192 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 10 1923

ROGER A. GRAUTEN Commissioner of Health.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80671

CERTIFICATE OF DEATH.

161-091 ✓ D 80671

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Regege

(a) RESIDENCE NO..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6-23

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johns Hopkins Hospital.

PARENTS

10 NAME OF FATHER Julian Regege

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Frances Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923, to Nov 6, 1923, that I last saw him alive on Nov 6, 1923, and that death occurred, on the date stated above, at 1 20 p m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 6 months Miscarriage

Cause unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan M. D.

11/6, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

NOV 9 1923

Commissioner Health.

Paris 0850 Clerk

D 80672

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 80672

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 587 Oxford Av. St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Talmadge Matthews

(Residence in Baltimore: No. 587 Oxford Av. St.; 15 yrs. ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: May 11, 1889 (Month) (Day) (Year)

7-AGE: 33 yrs. 5 mos. 28 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Garage Man
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER: Thos. Matthews

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Eliza Matthews

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ulysses Matthews

(Address) 210 N. Gilmor St.

15- Filed ... 192... Registrar.

Robert P. Harrison, Burial Permit Clerk

NOV 9 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) no hearing

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Heiskell M. D. (Coroner)

Nov 9 1923 (Address) 280 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18-PLACE OF BURIAL OR REMOVAL: Woodside G.A. Md. DATE OF BURIAL: Nov 10 1923

20-UNDERTAKER: Sam'l. H. Rose & Son ADDRESS 1400 Mosher

D 30673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30673

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Asquith St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elvina Johnson

(Residence in Baltimore: No. 207 Asquith St.; yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): widow

6-DATE OF BIRTH: about 1848 (Month) (Day) (Year)

7-AGE: 75 yrs. mos. ds.

If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Handy

(Address) 207 Asquith St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
instantaneous death

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Street car accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy (Coroner) M. D.

Nov. 9, 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 10 1923

20-UNDERTAKER: Sam'l R. Case Son — ADDRESS: 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80674

CERTIFICATE OF DEATH.

74-001 ✓

D 80674

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Mosher ST., 16 WARD)

2-FULL NAME Mrs Mary Annie Hill

(a) RESIDENCE NO. 1403 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Hill

6 DATE OF BIRTH (month, day, and year) unknown 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45.	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife + Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlottsville Va

PARENTS

10 NAME OF FATHER Isack Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottsville Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlottsville Va

14 Informant Roomer (Frances Reed

(Address) 1403 Mosher St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1923 to Nov 9, 1923, that I last saw her alive on Nov 8, 1923, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Nephritis + hypertension

(duration) 8 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1403 Mosher St.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Frank Saunders, M. D.

11-9-1923 (Address) 1123 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Olive	Nov 12 1923
20 UNDERTAKER Wm. H. Grace Son	ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

D 80675 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80675

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 E. Preston ST., 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Dailey

(a) RESIDENCE NO. 1222 E. Preston ST., 9th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 17 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur 086

(b) General nature of industry, business, or establishment in which employed (or employer): Meat Packers

(c) Name of employer: Kingan Provision Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): James J. Dailey 1222 E. Preston St.

15 Filed . . . . . 19 . . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to November 6, 1923, that I last saw him alive on November 6, 1923, and that death occurred, on the date stated above, at 12 35 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Probably Rheumatic origin)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis + Pericarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Nov 7, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rood Cemetery — DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: Geo. L. Routh — ADDRESS: 1730 Madison Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21 M&T 1500 Bks.

D 80676 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80676

100-sold

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 N. Calvert ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward M. Vickery

(a) RESIDENCE NO. 1223 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta S. Vickery

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	86	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Thomas Vickery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Stephen J. Vickery

(Address) 1223 N. Calvert St.

15 Filed ..., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8 1923

17

I HEREBY CERTIFY, That I attended deceased from 9-23, 1923, to 11-8, 1923.

that I last saw h[illegible] alive on 11-8, 1923,

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

BRONCHOPNEUMONIA

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary) ARTERIOSCLEROSIS

(duration) ? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Dorsey M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11-10 1923
20 UNDERTAKER Howard Jenkins Sons Co	ADDRESS Eutaw & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80677

CERTIFICATE OF DEATH.

37

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

2-FULL NAME Francis Cunningham

(a) RESIDENCE No. 849 W 34th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Annie Cunningham

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 57 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boston, Mass.

PARENTS

10 NAME OF FATHER: Patrick Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hospital Record.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/7/23 19

17 I HEREBY CERTIFY, That I attended deceased from 11/6/23, 19 ..... to 11/7/23, 19 .....

that I last saw h— alive on 11/5/23, 19 .....

and that death occurred, on the date stated above, at 12. midnight

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculous Peritonitis

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Apparently Illegible

(duration) ..... yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? ? Exploratory

Did an operation precede death? yes Date of 11/6/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) F. W. Kelly, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 11/10 1923

20 UNDERTAKER: Geo A Kelly Sullivan Stanley — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D 80678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80678

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4622 Elsrode Ave. Lamsville WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie L. Horseman

(a) RESIDENCE No. 4622 Elsrode ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 2/83

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
40	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Forelady 67

(b) General nature of industry, business, or establishment in which employed (or employer): Childen Dresses

(c) Name of employer: Hamburger & Co

9 BIRTHPLACE (city or town) (State or country): Charles Co. Md.

PARENTS

10 NAME OF FATHER: Geo. Horseman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Joan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas. E. Horseman

(Address): 1540 Gaswell Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 24, 1923, to Nov 8, 1923, that I last saw h[illegible] alive on Nov 3, 1923 and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/4, 19[illegible] (Address) 720 N. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hughesville Charles Co. Md.

DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

NOV 9 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Carline Hyppolite

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80679 90 D 80679

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~507~~ N. Wolfe St. ST., 7 WARD)

2-FULL NAME Mary M. Clemens

(a) RESIDENCE NO 507 N. Wolfe St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Clemens

6 DATE OF BIRTH (month, day, and year) March 17/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	53	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Stocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant George Stocker
(Address) 807 N. Wolfe St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably—Chronic Endocarditis

(Valvular Insufficiency).
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) History of Heart attacks
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Cotter, M. D.
(Coroner.)

Nov 8/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Nov 16 1923

20 UNDERTAKER Geo M. Enid & Son

ADDRESS 811 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 9 1923 Robert P. Harrison, Health Officer

Spec.—1-10-21—MAT—1500 Blks.

D 80680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80680

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 E. Lafayette ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude N. Dygert

(a) RESIDENCE No. 2101 E. Lafayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (oc) HUSBAND of (oc) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Sept 28. 1918

7 AGE — Years: 5 — Months: 1 — Days: 12 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant old

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Graham Dygert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Watertown N.Y.

12 MAIDEN NAME OF MOTHER: Gertrude Mershon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Princeton N.J.

14 Informant: Graham Dygert

(Address): 2101 E. Lafayette.

15 Filed . . , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1923, to Nov. 8, 1923, that I last saw her alive on Nov. 8, 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis 14 days.

Pneumonia Lobularis 1 week

T.B. Lungs Spine 3 years

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Pneumonia Hemorrhage (duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens, M. D.

11/8, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edmondson Ave

DATE OF BURIAL: 11/10 1923

20 UNDERTAKER: Robert F. Garrison

ADDRESS: 318 Eighth St.

NOV 9 1923 Robert F. Garrison, Funeral Director

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80681 — 80681

CERTIFICATE OF DEATH

188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 1 W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Williams

(a) RESIDENCE NO 1099 E. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70 / Nov 6			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Horse shoer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 036

9 BIRTHPLACE (city or town) Unknown (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records. (Address)

15 Filed ..... 192 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull - accidentally struck by auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. H. Kelly, M. D.

Nov 8 1923 (Address) (Coroner) 1823 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn, Cortland Co. N.Y.

DATE OF BURIAL Nov 9th 1923

20 UNDERTAKER E. J. Fanning & Son - 1938

ADDRESS 1386 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80682

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 717 Ramsay ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Schmidt

(a) RESIDENCE. NO. 717 Ramsay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 22, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Shrewsbrery, Pa.

PARENTS

10 NAME OF FATHER John H. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Charlotte Seibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Schmidt
(Address) 717 Ramsay St.

15 Filed ....., 19.... Registrar

NOV 10 1923

Robert F. Harrison
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1923, to Nov. 9, 1923, that I last saw him alive on Oct. 8, 1923, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) ..... yrs. ..... mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Joyce, M. D.

Nov. 9, 1923 (Address) 602 Wash. Blvd., Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov. 12 1923
20 UNDERTAKER	ADDRESS
Geo. Lienlach Sons	W. Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80683 80683

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alenda Armstrong

(a) RESIDENCE NO. 612 W. Lanvale St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 4, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Lowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) Johns Hopkins Hosp

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, to Nov 7, 1923,

that I last saw her alive on Nov 7, 1923,

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis - 2½ mos.

Secondary Pneumonia - 6 ds.

Pneumococcus peritonitis - 6 ds.

Empyema (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 1 Postmortem

Was there an autopsy? Yes

What test confirmed diagnosis? Urine analysis

(Signed) W. H. M'Eech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Co. DATE OF BURIAL 11/9 1923

20 UNDERTAKER Samuel Stansbury ADDRESS Mt Belle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchio.

No history.

D 80684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80684

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1202 McCulloh St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. H. Robinson

(Residence in Baltimore: No. 1202 McCulloh St., St.; 41 yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male colored

4-COLOR OR RACE.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH: about (Month) (Day) 1882 (Year)

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coachman
(b) General nature of Industry, business, or establishment in which employed (or employer): 123

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Perry Robinson

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Alberta Johnson

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alberta Robinson

(Address) 665 Pierce St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY — (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Heimsoth M. D. (Coroner)

Nov. 8 1923 (Address) 2502 Eastern Ave.

*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. 11/10 1923

20-UNDERTAKER. Samuel W. Hundley ADDRESS 578 N. Bradford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Joyner)

D 80685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80685

CERTIFICATE OF DEATH.

X 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Carey ST., 16 WARD)

2-FULL NAME Carrie Lee Joyner

(a) RESIDENCE No. 722 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Joyner

6 DATE OF BIRTH (month, day, and year): March 1902

7 AGE — Years: 21 — Months: 8 — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sallie Archer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant. (Address): Helen Webb 722 N. Carey St.

15 Filed ....., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10th, 1923, to Nov. 8th, 1923.

that I last saw h[illegible] alive on Nov. 7th, 1923.

and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Norfolk Va

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

11/8, 1923 (Address) 92 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Suffolk Va

DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: R. E. Gross

ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80686

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 208 N. ANN ST. ST., 6 WARD)

2-FULL NAME William Bailey (also known as William Dailey)

(a) RESIDENCE NO. 208 N. Ann St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Baugh Fertilizer Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lillie Strong

(Address) 1517 E. Monument St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inq iry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Ingigestion

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Coates, M. D. (Coroner.)

Nov 9 23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL at Berry Cemetery — DATE OF BURIAL nov 11 1923

20 UNDERTAKER Edward Bryson — ADDRESS 1631 Orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 80686

Personally appeared before me this 14th day of November 1913. Mr Eder Bryan, Undertaker, who made affadivit that William Bailey, who died at 208 N. Armstrong Nov 8-1913 is the same person who is known as William Bailey..

Seal Edward Bryan

Seal George H Gress
Notary Public

Spec.-12-23-21-E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80687

D 80687

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3907 Mt Pleasant Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Schubert

(a) Residence No. 3907 Mt Pleasant Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Schubert

6-DATE OF BIRTH (month, day and year) Feb. 14, 1859

7-AGE. 64 yrs. 8 mos. 22 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Muller

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea Bernstein

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Germany

14- (Informant) William Schubert
(Address) 3907 Mt Pleasant Ave

15-
Filed ..... 192 .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from 5-16-23 to 11-7-23 that I last saw her alive on 11-7-23 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ... yrs. ... mos. 10 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Frederick H. Herrmann M. D.

11/9-1923 (Address) 7919 Eastbourne

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Nov. 10, 1923
20-UNDERTAKER, H. Sander Sons	ADDRESS 1710 Pratt St.

NOV 9 1923

WHITE PARENT, WHITH CHILD; COLORED PARENT, COLORED CHILD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80688

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 80688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 E. 24th St., 12 Ward)

Registered No.....

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Townsend

(a) Residence No. 208 E. 24th St Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6-DATE OF BIRTH (month, day and year) Feb 2 1865 ~~Nov 9th~~ 23

7-AGE. 58 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Servant

(b) General nature of Industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer: 0/0

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John C Townsend

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary McDade

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14 (Informant) Thomas J Townsend

(Address) 500 S Carey St

15-

Filed ....NOV 10 1923 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 9th 23

17- I HEREBY CERTIFY, That I attended deceased from Nov 5th 1923 to Nov 9th 1923

that I last saw h.. alive on Nov 9th 1923

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

Several years

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Asthenia from Inanition

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur D Mansfield M. D

, 19 (Address) Calvert Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cemetery	Nov 10, 1923
20-UNDERTAKER.	**ADDRESS**
H Sanders & Sons	710 Fleet St

WHITE CARDS, WHITE ENVELOPES, RECORDS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80689

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 Belair Ave., ST., 26 WARD)

2-FULL NAME Christina Siemann.

(a) RESIDENCE NO. 2731 Belair Ave., ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of August Siemann.

6 DATE OF BIRTH (month, day, and year) April 29, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Dilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Kirkwood
(Address) Same address

15 Filed ..... , 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30th , 1923 , to Nov. 8th , 1923 , that I last saw her alive on November 8th , 1923 , and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no . Date of .....

Was there an autopsy? no .

What test confirmed diagnosis? .....

(Signed) A. L. Wilkinson , M. D.

, 19 (Address) 137 N. Belair Rd., Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Nov 10 1923

20 UNDERTAKER W M Rouse

ADDRESS 1230 N Smith

NOV 10 1923

Spec.—1-10-21—M&T—1500 Blks.

D 80690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80690

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. Montford Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michalina . Lipka

(a) RESIDENCE NO. 708 . S. Montford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Lipka

6 DATE OF BIRTH (month, day, and year) Sep. 10 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr William Wilczynski (Son)

(Address) 615 S. Patterson Park Ave

15 Filed ... ... , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 23, to Nov 9, 1923

that I last saw her alive on Nov 9, 1923

and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 10 23 (Address) 89 S. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Nov. 12 1923

20 UNDERTAKER: John A Weber — ADDRESS: 803 Bank St

Nov 01923 Robt. P. Harrison, Registrar Public Health Clerk

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80691

CERTIFICATE OF DEATH.

100-001

D 80691

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 930 N. Vincent ST., 19 WARD)

2-FULL NAME James Monfort Chesley

(a) RESIDENCE NO. 930 N. Vincent ST., ... WARD .....

(Usual place of abode) whole life (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9-1922

7 AGE — Years 11 Months 12 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin M. Chesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Mary V. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Benjamin M. Chesley (Address) 930 N Vincent St.

15 Filed NOV 1 1923, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9- 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18- 1923, to Nov. 8- 1923, that I last saw him alive on Nov. 8- 1923, and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11 10 1923

20 UNDERTAKER Dan'l Easton

ADDRESS 711 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Female

Spec.—5-19-13—M. & T.—500 Bks.

D 80692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Hanover ST. 23rd WARD) REGISTERED NO. C 1291

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Russell

(Residence in Baltimore: No. 1305 Hanover St. St. Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) 27 (Day), 1856 (Year)

7-AGE, 67 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Stirling

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter Mrs Odend'hal

(Address) 1224 W. Fayette St.

15-

Filed ....., 191.....

Registrar.

NOV 10 1923 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 17th 1923, to November 7th 1923, that I saw her alive on November 7th 1923, and that death occurred, on the date stated above, at 11:05 P.m.

The CAUSE OF DEATH* was as follows:

Chronic aortic insufficiency and chronic interstitial nephritis

(Duration) — yrs. 2 mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Heijbel M. D.

11/10, 1923 (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Woodlawn Cem.

DATE OF BURIAL. Nov. 10, 1923

20-UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 80693 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-004 D 80693

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 23 WARD)

2-FULL NAME John Miller

(a) RESIDENCE NO. 1534 Light St. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Miller

6 DATE OF BIRTH (month, day, and year) Aug 2 — 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Jos. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Records.

(Address)

15 Filed ....., 19 ..... Registrar

NOV 10 1923 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923 to Nov 9. 1923.

that I last saw him alive on Nov. 9 1923.

and that death occurred, on the date stated above, at 2:55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.
Left Middle Cerebral Artery.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cerebral Softening.

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Partial (Brain).

What test confirmed diagnosis? Autopsy.

(Signed) J. Elmer Hoffman M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Nov 13 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 East North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80694

CERTIFICATE OF DEATH.

74-001

D 80694

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Bayard ST.: 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Clash

(Residence in Baltimore: No. 1309 Bayard St.; 58 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem'l

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Jan (Month) 26 (Day), 1865 (Year)

7-AGE: 58 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt

PARENTS.

10-NAME OF FATHER: Wm Queen

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Martha Ross

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Clash

(Address) 1309 Bayard

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1923 to Nov 8 1923, that I saw h[er] alive on Nov. 8 1923, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Nov 9, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount

DATE OF BURIAL: Nov. 11, 1923

20-UNDERTAKER: [illegible]

ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Bks.

Not Clerk 11/20 26 Paul.

D 80695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80695

CERTIFICATE OF DEATH.

91-6

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered and all required information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 E Eager ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Siemonn

(a) RESIDENCE NO. 626 E Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H.

6 DATE OF BIRTH (month, day, and year) Dec. 11 - 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Baltimore

PARENTS

10 NAME OF FATHER John E. Schmidt

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Gabriella Kramer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Balto -

14 Informant Anna Siemonn
(Address) 626 E Eager St -

15 Filed ..... 2 ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov , 1922 to Nov 9- , 1923 ,

that I last saw her alive on Nov 9- , 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cirrosis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) G. H. Wollerech, M. D.

11-10-1923 (Address) 1631 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Nov. 12 1923 DATE OF BURIAL

20 UNDERTAKER Wm Cook ADDRESS 502 E Monroe

NOV 10 1923

Robert P. Daily
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

80696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80696

CERTIFICATE OF DEATH.

D-80696

96908 (1)

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Myrtle Gordon

(a) RESIDENCE NO. 225 W. Second St., Waynesboro, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. H. E. Gordon

6 DATE OF BIRTH (month, day, and year): Jan 28. 1871.

7 AGE: Years 52 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Waynesboro Pa.

PARENTS

10 NAME OF FATHER: A. J. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Elizabeth Stover

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: H. E. Gordon

(Address): Waynesboro Pa.

15 Filed . 19 Registrar

NOV 14 1923 ROBERT P. JACKSON Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 10, 1923,

that I last saw h er alive on Nov 10, 1923,

and that death occurred, on the date stated above, at 2 07 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (encapsulated tumor of left cerebellar portion angle)

(duration) 1½ yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

Operation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-10-23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Henry P. C. Wilson Jr. M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenhill Cemetery Waynesboro Pa

DATE OF BURIAL: Nov 13 1923

20 UNDERTAKER: F. E. Snook

ADDRESS: Waynesboro Pa

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant. Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure." "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Malignant

Spec.—1-10-21—M&T—1500 Bks. 80697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80697 X90 D 80697

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Joseph Hospital St., 9 WARD)

2-FULL NAME George C. Brookhart

(a) RESIDENCE NO. Harford Co Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 62 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Masterer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

051

9 BIRTHPLACE (city or town) Darlington (State or country) Harford Co

PARENTS

10 NAME OF FATHER Soloman Brookhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margarett Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Brookhart (Address) R2 Fallston Md

15 Filed NOV 11 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1923

17 I HEREBY CERTIFY That I attended deceased from Nov 7, 1923, to Nov 10, 1923, that I last saw him alive on Nov 10, 1923, and that death occurred, on the date stated above, at 3.58 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Schumann, M. D.

, 19 (Address) St Joseph Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Good Will Church Cem — DATE OF BURIAL: Nov 12 1923

20 UNDERTAKER: E G Kurtz & Son — ADDRESS: Darlington Md

Spec.—1-10-21 M&T 1500 10ks.

80698 Florence J. Warner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 13 D 80698

D 80698

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Johns Hopkins Hosp. ST., 7 WARD)

2-FULL NAME Florence Josiah Warner

(a) RESIDENCE NO. Elkins, W. Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 23 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct. 6, 1869

7 AGE: 54 Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Jacob D. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Sarah A. Shaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant: Johns Hopkins Hospital (Address) ROBERT R. KRAMER Burial Permit Clerk

15 Filed NOV 11 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1923, to Nov 10, 1923, that I last saw h.. alive on Nov 10, 1923, and that death occurred, on the date stated above, at 43 m.

The CAUSE OF DEATH* was as follows:

Acute Pyelonephritis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Contracted Vesical Orifice

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Yes Date of Nov 7, 1923.

Was there an autopsy? Yes

What test confirmed diagnosis? Suprapubic cystotomy

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkins West Va — DATE OF BURIAL: Nov 10 1923

20 UNDERTAKER: Joseph Abrams — ADDRESS: 22 B Way

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80699

CERTIFICATE OF DEATH.

57 D 80699

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St Josephs Hospital ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgeanna Robinson

(a) RESIDENCE NO. Park Ave. Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hunter R. Robinson

6 DATE OF BIRTH (month, day, and year): Nov. 10-1861

7 AGE: Years 61 Months 11 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Bukenmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): John Robertson Hamilton

15 Filed , 19 Registrar

NOV 7 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/9 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1923, to Nov. 9, 1923, that I last saw h[illegible] alive on Nov. 9, 1923, and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Myocardial insuff

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes mellatus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.M.S. & Laboratory

(Signed) Harold C. Gilfoy Jr. M.D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 11/12 1923

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Harford Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80700 — CERTIFICATE OF DEATH. — X 18 — D 80700

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST. 18 WARD)

2-FULL NAME William Harris

(a) RESIDENCE NO. 17 N Shroder ST., ... WARD South Carolina
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21 (mean)			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O'K
(c) Name of employer Eastern Specialty Construction Co.

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Ed Harris

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Pearl Black

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Pearl Harris
(Address) 17 N Shroder

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull - accidentally fell down elevator shaft. (duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Nov 8, 192 3 (Address) 1629 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., 1/2 mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? [redacted]

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dan Scott [redacted] Nov 10 1923 — DATE OF BURIAL

20 UNDERTAKER Osmond Tucker — ADDRESS 1407 Schroder St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT R. KRAUTER
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

6505 Surg 30701

HEALTH DEPARTMENT—CITY OF BALTIMORE

27 B 30701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 3 WARD)

2-FULL NAME Joseph Silberman

(a) RESIDENCE NO. 29 S. Exeter St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School - boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nathan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Rudak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St

15 Filed NOV 17 1923, 19 ..... Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 - 1923, to Nov 9 - 1923.

that I last saw him alive on Nov 9 - 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos + ds.

CONTRIBUTORY (Secondary) Abscess of lung.

(duration) 0 yrs. 9 mos. 7 ds.+

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 9, 1923

Was there an autopsy? No

What test confirmed diagnosis? X-ray -

(Signed) H. H. Mesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Bet Tahara Mt Carmel — DATE OF BURIAL 11/11 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80702

CERTIFICATE OF DEATH.

114

D 80702

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 542 N. Caroline ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Spellerberg

(a) RESIDENCE. No. 542 N. Caroline ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 57 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Spellerberg

6 DATE OF BIRTH (month, day, and year) May 3rd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Franz Rehker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Ottie Spellerberg (Address) 542 N. Caroline st.

15 Filed NOV 1 1923 19 ERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Oct 28 1923, that I last saw h[illegible] alive on Oct 28 1923, and that death occurred, on the date stated above, at 10:35 a. m.

The CAUSE OF DEATH* was as follows:

Cardio Endocarditis

(duration) 2 yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 7, 1923 (Address) 1501 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 12th 1923
20 UNDERTAKER E. Schlomanson	ADDRESS 1034 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80703

CERTIFICATE OF DEATH.

90 ✓ D 80703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 S. Sharp St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Waters.

(a) RESIDENCE NO 1040 S. Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White,	Married

5a If married, ~~widowed or divorced~~ ~~HUSBAND of~~ (or) WIFE of Abraham L. Waters

6 DATE OF BIRTH (month, day, and year) April 14, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48 ~~48~~	6	25.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Klein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Dora Sipple.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Abraham L. Waters. (husband)
(Address) 1040 S. Sharp St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Nov, 10, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Nov 12th 1923

20 UNDERTAKER E. Schloman & Son ADDRESS Baltimore

NOV 11 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80704

CERTIFICATE OF DEATH.

129 D 80704

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2807 Guilford ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie B. Baldwin

(a) RESIDENCE NO. 2807 Guilford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt. Baldwin

6 DATE OF BIRTH (month, day, and year): Nov. 19th 1851

7 AGE — Years: 71 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housedulies

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie M. Scheffenacker

(Address) 2807 Guilford

15 Filed . . . . 19 . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1923. to Nov 9 1923.

that I last saw h alive on Nov 8 1923.

and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Endocard

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Nephritis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jeffers Buel M. D.

11/10 1923 (Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Nov 1923

20 UNDERTAKER: Geo W. Fair & Son — ADDRESS: 811 W Lexington

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80705

CERTIFICATE OF DEATH.

188-603

D 80705

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 7 WARD)

2-FULL NAME William Pistel

(a) RESIDENCE No. 812 N. Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): Oct. 10, 1860

7 AGE — Years: 63 — Months: — Days: 28 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stable-man

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

086

9 BIRTHPLACE (city or town) (State or country): Baltr., Md.

PARENTS

10 NAME OF FATHER: Geo. Pistel (deceased)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Mary S. Nyeher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Mrs. John Hall

(Address) 812 N. Chapel St.

15 Filed , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/8 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/3/1923, to 11/8/1923, that I last saw him alive on 11/8/1923, and that death occurred, on the date stated above, at 9.20 P.m.

The CAUSE OF DEATH* was as follows:

Contusion of r. shoulder & right hip

subsequently injected

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary): Toxemic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? — Date of Oct 10, 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. A. Thompson, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 12 1923

20 UNDERTAKER: Geo W Fink + Son 811 — ADDRESS: N Wolfe St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

456.
Geo Chester Blades md
Coroner at Large
Accident - Fall from
Auto Truck

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80706

CERTIFICATE OF DEATH.

90 D 80706

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 324 S. Eden St (St.) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George G. Smith

(a) RESIDENCE. NO. 324 S. Eden St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? 39 yrs. 8 mos. 17 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Eva Smith

6 DATE OF BIRTH (month, day, and year): January 3 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): for H. W. James

(c) Name of employer: Lumber Company

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Louis Rudel 167 S. Caslay St.

15 Filed NOV 11 1923 Registrar

Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Nov. 8, 1923, that I last saw h[im] alive on Nov. 7, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessano, M. D.

11.10.23. 1923 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 11 1923

20 UNDERTAKER: Wendell Hopper Son

ADDRESS: 37 S. Howard

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80707

CERTIFICATE OF DEATH.

1291

D 80707

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 200 Roland Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME { Thomas Harop.

(a) RESIDENCE. No. 200 Roland ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Thresa Harop

6 DATE OF BIRTH (month, day, and year): May 31 1838

7 AGE — Years: 85 Months: 5 Days: 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): R & Harop.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Edw Harop

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Martha Mcleod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant: Annie Harop
(Address): 200 Roland Ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27. 1923. to Nov. 8. 1923.

that I last saw him alive on Nov. 8. 1923.

and that death occurred, on the date stated above, at 12 midnight.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary): Senile Arteriosclerosis

(duration) 3 yrs. mos. d.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cerebellopons

(Signed) M. Tutwiler Poole, M. D.

11/9. 1923 (Address) 422 Rolands—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Lampeter	Nov 11 1923
20 UNDERTAKER	ADDRESS
E. F. Wiedefeld Jr	501 E 22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 39708 B 80708

1. PLACE OF DEATH Johns Hopkins Hosp. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1601 ST., 7 WARD)

2. FULL NAME Maiddie Stanford

(a) RESIDENCE NO. Bureau of Yards & Docks Navy D. C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Capt. Homer Stanford

6 DATE OF BIRTH (month, day, and year): Dec 3, 1871

7 AGE: Years 51 Months 10 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tenn

PARENTS

10 NAME OF FATHER: Carrington —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Marie Boddie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Record (Address): John Hopkins Hosp

15 Filed ..... 19 ..... Registrar

NOV 1 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, to Nov 10, 1923, that I last saw h[illegible] alive on Nov 10, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? yes Date of Sept 7, 1923

Was there an autopsy? yes

What test confirmed diagnosis? Observation

(Signed) Cecil K. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: Nov-10-1923

20 UNDERTAKER: Stewart & Mowen Co ADDRESS: 107 W Mulberry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80709

CERTIFICATE OF DEATH.

101-001

D 80709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Railroad Av ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Kelby

(a) RESIDENCE. No. 3710 Railroad ST. 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Mar 2 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Laud

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 46

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Philip Kelby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant (Address) Philip Kelby 3710 Railroad Av

15 Filed ... 19 ... Registrar

NOV 1 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7 1923, to Nov 9 1923, that I last saw h[illegible] alive on Nov 9 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

0 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C F Culler M. D.

(Address) 3701 Dulaney Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	Nov 12 1923

20 UNDERTAKER A S Marshall ADDRESS 3539 Talbot Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 80710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80710

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Denver St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara M. Bunn.

(a) RESIDENCE NO 1107 Denver ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of William Bunn.

6 DATE OF BIRTH (month, day, and year) April 25, 1868.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William H. Higdon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Vickers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Mary Peacock (sister)
(Address) 943 S. Paca St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov. 10, 192 3 (Address) 1317 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL 11/12/ 1923

20 UNDERTAKER Maynard E. Flynn ADDRESS 14 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

NOV 11 1923 ROBERT M. KRAUTER Burial Permit Clerk

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80711

CERTIFICATE OF DEATH.

D 80711

Registered No. 164

1-PLACE OF DEATH

City of BALTIMORE: (No. 746 W. Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Julia Droescher

(a) Residence No. 746 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 22 July 1837

7-AGE, 86 yrs. 3 mos. 20 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Rev. Merkel

(Address) 746 W. Lexington St.

15- Filed ..... 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 9 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Nov 9 1923

that I last saw h.. alive on Nov 9 1923

and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

old age uncertain

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Heimann M. D.

11-10, 1923 (Address) 1001 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Pauls Cemetery — DATE OF BURIAL, Nov. 11, 1923

20-UNDERTAKER, Louis Heimann — ADDRESS 323 Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D 80712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 80712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 Dillon St ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wojtas

(a) RESIDENCE NO. 2127 Dillon St ST., 1 WARD 15

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
		6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md (State or country) U. S. A.

PARENTS

10 NAME OF FATHER Henry Wojtas

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Mary Krupka

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Henry Wojtas (Address) 2127 Dillon St

15 Filed ..., 19... Registrar

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 , 1923 , to Nov. 9 , 1923.

that I last saw him alive on Nov. 9 , 1923

and that death occurred, on the date stated above, at 11-15 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia, following diarrhoea (duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. B. Brotulskas , M. D.

11-10 1923 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov-11 1923
20 UNDERTAKER	ADDRESS
Stephen F Fialkowski	1000 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80713

CERTIFICATE OF DEATH.

111-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N. Preston ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Lorenzo Davis

(a) RESIDENCE NO. 20 N. Preston ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Etta S. Davis.

6 DATE OF BIRTH (month, day, and year): April 8-1860

7 AGE — Years: 63 — Months: 7 — Days: 1 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer): of the Gospel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Nancy S. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Nancy Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Ella S. Davis.

(Address) 20 N Preston St.

15 Filed NOV 11 1923 Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov 9, 1923,

that I last saw h alive on Nov 9, 1923

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? ~~Autopsy~~ findings

(Signed) Ralph Leahy M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk Cem.

DATE OF BURIAL: Nov 12 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S Wolfe St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80714

D 80714

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1114 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Biddison Barrett

(a) Residence No. 1114 Ensor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred L. Barrett

6-DATE OF BIRTH (month, day and year) Mar 13-1855

7-AGE, 68 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Keely

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Bowland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Fred L. Barrett

(Address) 1114 Ensor St.

15- Filed NOV 11 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 9, 23

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1923 to Nov. 9, 1923, that I last saw her alive on Nov. 8, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carbuncle & Sepsis

.....(Duration).....yrs.....mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

.....(Duration).....yrs. 1 mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Lee Magruder, M. D

11-9, 1923 (Address) 120 S. Paca St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov. 12, 1923

20-UNDERTAKER, E. H. Krause — ADDRESS 703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No history

Spec.—1-10-21—M&T—1500 Bks.

D 80715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 80715

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Fairview Ave., ST., Curtis Bay 25 WARD)

2-FULL NAME Wilhelmina Lux

(a) RESIDENCE NO. 1602 Fairview Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Carl Lux

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Boldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eichenroth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Frank A. Lux 1602 Fairview Ave. - Curtis Bay

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2nd, 1923, to Nov. 9, 1923, that I last saw ~~her~~ alive on Nov. 8, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) mild cardiac decompensation

(duration (?) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thos. B. Davis, M. D.

11/9/1923 (Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Nov. 12 1923

20 UNDERTAKER: F. A. Frame & Son ADDRESS: 703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80716

CERTIFICATE OF DEATH.

D 80716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. 25 WARD)

REGISTERED NO. 1853

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaw Kaminski.

(a) RESIDENCE NO 807 Curtis Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -- --- --- --

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. South

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Car Shop.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant John Koe.

(Address) 807 Curtis Ave.

15 Filed NOV 11 1923 192 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy & inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Accidental fall down a stairway.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos, ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

Nov, 10, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Accident

807 Curtis Ave. November 7, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL Nov 12 1923

20 UNDERTAKER Wm Fiallowski ADDRESS 118 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80717

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (No.....ST.,.....WARD)

2 FULL NAME Joseph Michael

(a) RESIDENCE NO. Severn Anne Arundel Co, Md WARD Severn Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct. 13, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Carrie Streyz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Record

(Address) Johns Hopkins Hosp

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 10, 1923, that I last saw him alive on Nov 10, 1923, and that death occurred, on the date stated above, at 4.22 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery (Flexner)

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Reese M. D.

(Address) Johns Hopkins Hospital

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Nov 12 1923

UNDERTAKER Wm Fiallowell

ADDRESS 1618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80718

CERTIFICATE OF DEATH.

74001 ✓

D 80718

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1169 Cleveland ST., 21 WARD)

2-FULL NAME John Geary

(a) RESIDENCE No. 1169 Cleveland ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nora Donnelly

6 DATE OF BIRTH (month, day, and year): — — 1869

7 AGE: Years 54 | Months — | Days — | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): C & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Geary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hennessy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Nora Geary

(Address): 1169 Cleveland Ave

15 Filed ....., 19 .....

NOV 11 1923 ROBERT R. KRAUTER, BURIAL PERMIT CLERK

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-8- 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-7-, 1923, to 11-8, 1923,

that I last saw h— alive on 11-8-, 1923,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Davis, M. D.

, 19 (Address) 1169 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Patapsco Hall

DATE OF BURIAL: 11/14 1923

20 UNDERTAKER: Thos. F. Kelly & Sons

ADDRESS: 1318 Eutaw

Spec.—1-10-21—M&T—1500 Blks. 80719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80719 X 117 D 80719

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette and Sayer St. 20 WARD)

2-FULL NAME Byron Wallace Shull

(a) RESIDENCE NO. Woodbine, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Shull

6 DATE OF BIRTH (month, day, and year) Feby. 6 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	31	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER A. Byron Shull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Ida Wallace,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant E. W. Pickett, (Address) Woodbine, Md.

15 Filed NOV 12 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1923, to Nov. 11 1923, that I last saw him alive on Nov. 11 1923, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. ~ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11/6/23

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. Tests.

(Signed) H. W. Rowell, M. D.

11/11/1923 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbine, Maryland. DATE OF BURIAL Nov. 13-1923.

20 UNDERTAKER C. M. Waltz ADDRESS Mayfield, Md.

Spec.—1-10-21—M&T—1500 Bks.

D 80720 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 80720

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 44 Kelly Ave ST., 27 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Wing

(a) RESIDENCE NO. 44 Kelly Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Sngl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-13-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Solomon Wing

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Julia Boyd

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Solomon Wing
(Address) 44 Kelly Ave

15 Filed NOV 17 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 11. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5. 1923 to Nov 10 1923, that I last saw him alive on Nov 10 1923, and that death occurred, on the date stated above, at 4. Am m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia following Bronchitis.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) C. H. Beeler M. D.

11. 11. 1923 (Address) 1st Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

M-Zion Cem. Green Nov-13 1923

20 UNDERTAKER — ADDRESS

F. S. Chatman Penna Ave
Funl. P. Hensley 478 W. Biddle

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80721

D 80721

CERTIFICATE OF DEATH.

155

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St Joseph's Hospital (St.) 10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bernard.

(a) RESIDENCE NO. 1036 Mordecai (St.), (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bernard

6 DATE OF BIRTH (month, day, and year): Jan 8, 1878

7 AGE — Years: 45. Months: 10 Days: 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10 NAME OF FATHER: William Valar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ark

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Estelle Davis

(Address) 1036 Mordecai St

15 Filed ..... 19 .....

ROBERT R. KRAUTER

NOV 21 1923

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 9 1923

17 I HEREBY CERTIFY That I attended deceased from Nov 5 1923, to Nov 9, 1923,

that I last saw h alive on Nov 9, 1923,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Osteomyelitis - Spine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) John G. Schenuit, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Nov 12, 1923

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 125 E. North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80722 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80722

CERTIFICATE OF DEATH.

6 105

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 155 N. Milton Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Johanna Freesemann

(a) Residence No.... 155 N. Milton Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacab Freesemann

6-DATE OF BIRTH (month, day and year): Dec 29, 1851

7-AGE: 71 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant): Jacab A. Freesemann

(Address): 155 N. Milton Ave

15- Filed..... 192.....

NOV 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 8 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1923 to Nov 8 25 19.....

that I last saw h.. alive on Nov 8 1923

and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Brochial Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Block

(Duration) yrs. 1 mos. 1 week

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Jas. Sander Sons, M. D.

19 (Address) 1125 N. Milton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Pauls Cemetery	Nov 12 1923
20-UNDERTAKER.	**ADDRESS**
H. Sander Sons	1100 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80723 D 80723

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Vest

(a) RESIDENCE NO. 732 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	28	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Vest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Arabelle Behm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant University Hospital Records (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to Nov. 11, 1923, that I last saw h[illegible] alive on Nov. 11, 1923, and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Indigestion (intestinal) with diarrhoea (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Signs + Symptoms

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 13 1923

20 UNDERTAKER George L. Schwab — ADDRESS 410 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 21 1923 ROBERT R. KRAUTER, Register Records Clerk

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80724

CERTIFICATE OF DEATH.

D 80724

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 424 So. Caroline ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Cooper

(a) RESIDENCE NO 424 So. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Cooper

6 DATE OF BIRTH (month, day, and year) March 4 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Carrie Cooper
(Address) 424 So. Caroline St

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Nov. 9th 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Nov 12 1923
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

NOV 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80725

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Johnson

(a) RESIDENCE NO. 1917 Front St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 6 H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joshua Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Municipal Hospital Records.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 19 23

17 I HEREBY CERTIFY, That I attended deceased from October 31, 19 23, to November 9, 19 23, that I last saw h alive on November 9, 19 23, and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Evans, M. D.

11-, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL Leon Greely MD

DATE OF BURIAL Nov 13 19 23

17 UNDERTAKER Sam'l W. Chase Hon

ADDRESS 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80726

CERTIFICATE OF DEATH.

89 ✓

D 80726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1420 Pennsylvania Ave (ST.) (WARD) 14

2-FULL NAME Ethia Gross Bell

(a) RESIDENCE No. 1420 Penn Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 170

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Seattle Wash Georgiana

PARENTS

10 NAME OF FATHER Wm Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rosie Lee
(Address) 1420 Pennsylvania Ave

15 Filed ..... 19 ..... Registrar

NOV 12 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Nov 11th 23.

that I last saw her alive on Nov 10, 1923

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis of Heart

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. 1 hr. — ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Harry F Brown, M. D.

11/12 1923 (Address) 1501 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MtAuburn	Nov 14 1923
20 UNDERTAKER	ADDRESS
Sam'l N. Crane Son	1400 Madison

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80727 — 31 D 80727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 N. Schroeder ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Dorsey

(a) RESIDENCE NO. 324 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. Dorsey.

6 DATE OF BIRTH (month, day, and year) May 30th 95

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) Mt. Airy (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Deborah Hynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt. Dorsey (Address) 324 N. Schroeder St.

15 Filed ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10th, 1923, to Nov. 10th, 1923

that I last saw h— alive on Nov. 9th, 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) A. Levi Chisolm M. D.

11/12/1923 (Address) 824 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL McDaniel Md

DATE OF BURIAL Nov 13 1923

20 UNDERTAKER Sam'l H. Chisholm

ADDRESS 1400 Mosher

1923 ROBERT R. KRAUTER, Notary Public, Baltimore City

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80728

CERTIFICATE OF DEATH.

D 80728

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N Gilmor ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gene A Brown

(a) RESIDENCE NO. 1222 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Howard S Brown

11 BIRTHPLACE OF FATHER (city or town) md

(State or country)

12 MAIDEN NAME OF MOTHER Ed Hatton

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant Howard S Brown

(Address) 1222 N Gilmor St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923, to Nov 11, 1923,

that I last saw h Ev alive on Nov 11, 1923,

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

11/11, 1923 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Nov 13 1923

20 UNDERTAKER Clarence E Wright & Harry Cary ADDRESS

NOV 21923

ROBERT R. KRAUTER

DEPUTY REGISTRAR

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Whooping Cough

Spec.—1-10-21—M&T—1500 Bks.

D 80729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (INC.) De Soto Apts St Paul and 35th Sts N WARD)

2-FULL NAME Alice Maude McLaughlin

(a) RESIDENCE NO St Paul and 35th " STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip S. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes C. Lipps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary L. McLaughlin

(Address) St Paul and 35th Sts

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1912, to Nov 9, 1923.

that I last saw her alive on Nov. 9, 1923,

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency & Stenosis.

(duration) Chronic Early Childhood.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jno A Litscher, M. D.

, 19 (Address) 1025 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem DATE OF BURIAL Nov. 13, 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 1 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80730 D 80730

CERTIFICATE OF DEATH.

X 135

1-PLACE OF DEATH Johns Hopkins Hosp

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Joseph D. Patton

(a) RESIDENCE NO. Cleveland Ohio ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Patton

6 DATE OF BIRTH (month, day, and year) Nov 27. 1839

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Matilda Helfenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Regent
(Address) 926

15 Filed ..... , 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923. to Nov 11, 1923.

that I last saw he alive on Nov 11, 1923.

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - pericarditis
(post operative)

(duration) yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Prostatectomy

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Nov. 5

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Charles G. Bidgood, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hickaville Ohio	Nov. 12 1923
20 UNDERTAKER	ADDRESS
John A. Mitchell	1201 W. Fayette St.

D 80731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Walbrook Road Pimlico Hotel Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morgan Courtenay Knight

(Residence in Baltimore: No. Boarding House St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH June 22 1912
(Month) (Day) (Year)

7-AGE. 11 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. Francis Coppedge Knight

11-BIRTHPLACE OF FATHER. (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER. Mabel Lyman

13-BIRTHPLACE OF MOTHER. (State or Country) New Orleans La

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel L Knight

(Address) Boarding House

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

DEC 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 30 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)
Dec 1 192 3 (Address) 3813 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Green Mt Cem	Nov 2 1923
20-UNDERTAKER.	ADDRESS
Wm Leuckenhoff	Norman Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21-E.B.R.S.-400 Bks.

D 80732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80732

CERTIFICATE OF DEATH.

21 · 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 822 Mangold St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schiffmacher

(a) Residence No. 822 Mangfold St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Adele K. Schiffmacher

6-DATE OF BIRTH (month, day and year): Feb. 14 1850

7-AGE: 73 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): Embroiderer

(c) Name of employer: .....

9-BIRTHPLACE (city or town): Mulhausen
(State or Country), Alsace

PARENTS.

10-NAME OF FATHER, Joseph Schiffmacher

11-BIRTHPLACE OF FATHER (city or town) Mulhausen
(State or Country), Alsace

12-MAIDEN NAME OF MOTHER, Marie A. Grimm

13-BIRTHPLACE OF MOTHER (city or town) Mulhausen
(State or Country), Alsace

11- (Informant) Adele K. Schiffmacher
(Address) 822 Mangold St.

15-
Filed ....., 192.....
Registrar.

ROBERT R. KRAUTER.
NOV 21923
Health Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 9 1923

17- I HEREBY CERTIFY, That I attended deceased from May — 1922 to Nov 9 1923
that I last saw h.. alive on Nov 9 1923
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis Fatal

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ignatius Dill M. D.

11/11 1923 (Address) 1433 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 13 1923

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chr. Nephritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80733 D 80733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney J. Nimmo

(a) RESIDENCE NO. Johnson Mt (305 York Road) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — Carrie B. Warner

6 DATE OF BIRTH (month, day, and year) April 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint spanning 6

(b) General nature of industry, business, or establishment in which employed (or employer) Paint spanning

(c) Name of employer Own establishment

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John E. Nimmo

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER [illegible] Runyan

13 BIRTHPLACE OF MOTHER (city or town) Liverpool
(State or country) England

14 Informant Hospital Record
(Address)

15 Filed NOV 12 1923, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 8, 1923, to November 11, 1923,

that I last saw h[illegible] alive on November 11, 1923,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) 12 hrs.

CONTRIBUTORY (Secondary) myocarditis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/13 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80734

CERTIFICATE OF DEATH.

90 D 80734

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 533 N Wolfe ST., 7 WARD)

2-FULL NAME Julia E. Greeley

(a) RESIDENCE NO 533 N. Wolfe St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Greeley

6 DATE OF BIRTH (month, day, and year) May--1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ------ Golley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary McDonald
(Address) 533 N. Wolfe St.

15 Filed ..... 192 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

NOV 12 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mc Cain, M. D.
(Coroner.)

Nov 12/23 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral Cemetery DATE OF BURIAL 11/13/1923

20 UNDERTAKER John A Moran ADDRESS 3000 E Balt St

INSTRUCTIONS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Brennan D 80735

HEALTH DEPARTMENT—CITY OF BALTIMORE D 80735

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 East 20th. St. ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Byrne Brennan

(a) RESIDENCE NO. 1112 East 20th. St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Brennan

6 DATE OF BIRTH (month, day, and year) Mar. 4, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alice B. Reynolds

(Address) 1112 E. 20th. Street

15 Filed ....., 19 ..... Registrar

NOV 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from September 11, 1923, to Nov. 10, 1923, that I last saw her alive on " 9, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus and Stomach 6 mos.

Arteriosclerosis (duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Auto-Intoxication. (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of "

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. W. Coolahan, M. D.

10/10/23, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 13 1923
20 UNDERTAKER	ADDRESS
Harry N. Arnacost	4204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D 80736

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 15 WARD)

2-FULL NAME William Stewart

(a) RESIDENCE NO. 144 a Woodyear ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gaithersburg Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant David Eaton

(Address) 716 Lemmon ave.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Nov 8, 1923, that I last saw him alive on Nov. 8, 1923, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Perforated Ulcer Pepsin

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 7, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) J. Norwood Wilson M.D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-12-1923

20 UNDERTAKER David Eaton

ADDRESS 716 Lem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80737

CERTIFICATE OF DEATH.

38 B 80737

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Thomas

(a) RESIDENCE NO. 1408 N. Gilmore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joseph Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mary Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15. Filed NOV 21 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 8, 19 23, to November 8, 19 23,

that I last saw h alive on November 8, 19 23,

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Cirrhosis of Liver

(duration) yrs. 6 mos. (Estimated) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab + Autopsy

(Signed) Claude A Pierce, M. D.

21-2-19 23 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-12 1923

20 UNDERTAKER David Eastwood

ADDRESS 916 Penn

Cor.—1-12-23—M&T—100 Bks.

Lewis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80738

CERTIFICATE OF DEATH.

90 D 80738

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Pine St. 17 WARD)

2-FULL NAME Susie Lewis

(a) RESIDENCE No. 408 N Pine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Col	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Crittendon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jim Bennett
(Address) Jersey City N. J.

15 Filed ..... 192 .....

NOV 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) J. H. Beasley, M. D.
(Coroner.)

11-10, 1923 (Address) 117 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-13-23
20 UNDERTAKER	ADDRESS
David Easton	Dead

NOTICE—PRINT, WITH FADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80739

CERTIFICATE OF DEATH

D 80739

57

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE (No. 2209 W. Fulton St., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Keegan

(a) RESIDENCE No. 1209 W. Lombard St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 12 1871

7 AGE: Years 52 Months 3 Days 9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Agnes Keegan

(Address): 1209 Fulton Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov 10, 1923,

that I last saw him alive on Nov 10, 1923,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

Diabetic gangrene

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Analysis

(Signed) John G. Schneidich M. D.

(Address) St. Joseph's Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Nov 13 1923

20 UNDERTAKER: Clotworthy & Sons

ADDRESS: 17 W. Biddle

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 80740 — 90 D 80740

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: No 2421 Fait Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Pruchniewska

(a) RESIDENCE. No. 709 S. Rose. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Pruchniewska

6 DATE OF BIRTH (month, day, and year): May 10th 1863

7 AGE — Years: 66. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Annie Richter

(Address): 709 S. Rose st

15 Filed . 19 . Registrar

ROBERT R. KRAUTER

Burial Permit Clerk

NOV

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 6 . 1923 . to Nov 10 . 1923 .

that I last saw her alive on Nov 10 . 1923 .

and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

8

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Incomplete

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Daniel Miller . M. D.

. 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross German Hill Rd	Nov 13th 1923
20 UNDERTAKER	**ADDRESS**
Martin W. Dippel	37 S. Conkling St

Spec. 1-10-21 M&T 1500 Blks.

McNeal

D 80741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 80741

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 E. Biddle St. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie McNeal

(a) RESIDENCE No. 610 E. Biddle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C. McNeal

6 DATE OF BIRTH (month, day, and year): Jan. 24, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John C. McNeal

(Address): 610 E. Biddle St

15 Filed ... , 19 ...

NOV 1 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1923, to Nov. 9, 1923,

that I last saw her alive on " " , 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis (1 wk.)

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Geo. W. Corbin, M. D.

10/10 1923 (Address) 24 N. Fulton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: Nov. 12 1923

20 UNDERTAKER: Geo G Corbin

ADDRESS: 1900 Highland Ave

Spec.—1-10-21—M&T—1500 Bks.

16726 B 807-42

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 B 807-42

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7 WARD)

2-FULL NAME Charles Wright

(a) RESIDENCE NO. 904 McDonough St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 13 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Julia Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Record

(Address) Johns Hopkins Hosp

15 Filed NOV 1 21923, 19 ROBERT R. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1923, to Nov 10, 1923, that I last saw him alive on Nov 10, 1923 and that death occurred, on the date stated above, at 2 35 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture

(Signed) H. H. Wreck, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov 13 1923

20 UNDERTAKER Miss R. C. Elliott — ADDRESS 1727 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RECORD BOOK FOR BINDING

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Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80743

CERTIFICATE OF DEATH.

101-001

D 80743

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1206 Edward St ST., 5 WARD)

2-FULL NAME William Powell

(a) RESIDENCE NO 1206 Edward St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year) UNknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lottie Stevens
(Address) 508 N. Central Ave

15 Filed ..... 192 ..... Registrar

ROBERT R. KRAUTER,
NOV 1 21923
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. Scott Powell, M. D. (Coroner.)

Nov. 12/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Antrim Cemetery	Nov. 13 1923
20 UNDERTAKER Mrs J.R.G. Elliott	ADDRESS 1228 Edmondson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80744

CERTIFICATE OF DEATH.

113 D 80744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Alice White

(a) RESIDENCE NO 528 East St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Aug 1/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Alice White

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Arthalia Jones (Aunt)
(Address) 508 East St

15 Filed NOV 14 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastric Indigestio

(duration) yrs. mos. ds.

(Signed) J. S. H. Cotton, M. D.
(Coroner.)

Nov 10/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blackstone Va.

DATE OF BURIAL 11/13 1923

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1926 Eastlawn

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80745

CERTIFICATE OF DEATH.

90 D 80745

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 E Lanvale ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Elizabeth Kern

(a) RESIDENCE NO. 1618 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Kern

6 DATE OF BIRTH (month, day, and year): Mar 12. 1860

7 AGE — Years: 62 — Months: 7 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Bohnlofink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs W. R. Watson

(Address): 1618 E Lanvale St

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923 to Nov. 11, 1923.

that I last saw her alive on Nov. 10, 1923,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Albert Kingsbury M. D.

11/14 1923 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: John Ellrich

ADDRESS: 2005 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PUBLIC LIBRARY ROBERT R. KRAUTER Burial Permit Clerk.

Spec—12-23-21—E.B.F.S.—400 Bks.

D 80746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 80746

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 210 N. Arlington Ave. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Cusick

(a) Residence No. 210 N. Arlington Ave. Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~of~~ of Mary Cusick

6-DATE OF BIRTH (month, day and year) Dec 5-1850

7-AGE. 72 yrs. 11 mos. 5 ds.

If LESS than 1 day ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. "Laborer."

(b) General nature of Industry, business, or establishment in which employed (or employer). in cemetery

(c) Name of employer. Has not worked for 4 yrs.

9-BIRTHPLACE (city or town)... (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Cusick

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Annie Murry.

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Ireland

14- (Informant) Wm Joseph Cusick

(Address) 2004 Ridgewood Ave.

15- Filed NOV 1 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 10-23

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1923 to Nov 10, 1923.

that I last saw him alive on Nov 6 - 1923

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral degeneration.

(Duration) 2 yrs. - mos. - ds.

(CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) 4 yrs. - mos. - ds.

18-Where was disease contracted If not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) M Bowman Hood M. D

Nov 10, 1923 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Peters Cemetery	Nov 13, 1923
20-UNDERTAKER.	ADDRESS
John J. Bowman & Son	1600 E. Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 80747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80747

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Margaret Elizabeth Legg

(a) RESIDENCE NO. 1726 E. Madison ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] 56 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of: Hanks E. Legg

6 DATE OF BIRTH (month, day, and year): Dec 25th 1866

7 AGE: Years 58; Months 10; Days 17; If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital City

15 Filed ..... 19 ..... Registrar

NOV 1 1923 ROBERT B. KRAUTER, CHIEF REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923 to Nov. 10 1923

that I last saw her alive on Nov. 10 1923

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) A. Feldsmith M. D.

10/11 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Nov 14th 1923

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter attached

HEALTH DEPARTMENT—CITY OF BALTIMORE

Straub D 80748

CERTIFICATE OF DEATH.

128

D 80748

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2623 Dulaney St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~August H.~~ Gustave Straub

(a) RESIDENCE NO. 2623 Dulaney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late Dorothy Straub

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vocational Training

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER August Straub

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Gumpman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Sarah Dembinsky

(Address) 2623 Dulaney Street

15 Filed NOV 1 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1923, to Nov. 10, 1923.

that I last saw him alive on " " 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ac. Dilitation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan, M. D.

10/10/23 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 15 1923
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1551 [illegible]

DR. EDWARD V. COOLAHAN
BALTIMORE, MD.

December 20, 1923.

Dr. C. Hampson Jones,
Health Department

Dear Sir:

Kindly change name on death certificate from August H. Straub to Gustave Straub as this is the name under which the deceased enlisted.

Very truly yours,

Edw. V. Coolahan, M.D.

EVC/MK.

t neoplasms); *Measles;*
c *valvular heart disease;*
lts, etc. The contributory
nt) affection need not be
Example: *Measles* (disease
ronchopneumonia (second-
nere symptoms or terminal
ienia," "Anemia" (merely
"Collapse," "Coma," "Con-
ngenital," "Senile," etc.),
"Heart failure," "Hemor-
sinus," "Old age," "Shock,"
., when a definite disease
cause. Always qualify all
ildbirth or miscarriage, as
"PUERPERAL *peritonitis*,"
ch surgical operation was
DEATHS state MEANS OF
ACCIDENTAL, SUICIDAL, or
y such, if impossible to
mples: *Accidental drown-*
train—accident; Revolver
Poisoned by carbolic acid
nature of the injury, as
nsequences (e. g., *sepsis,*
der the head of "Contribu-
on statement of cause of
ittee on Nomenclature of
ɔtation.)

FURTHER STATEMENTS
SICIAN.

Spec.—1-10-21—M&T—1500 Bks.

D 80749

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 80749

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1060 Vine ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Howden

(a) RESIDENCE NO. 1060 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Mamie Howden

6 DATE OF BIRTH (month, day, and year): March 17, 1877

7 AGE — Years: 46 — Months: 7 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Howden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Summerville

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mamie Howden 1060 Vine St

15 Filed ..., 19 ... Registrar

NOV 7 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Nov 10, 1923, that I last saw him alive on Nov. 9, 1923, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary): Lobular Pneumonia (Terminal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Davis M. D.

(Address) 1191 Arrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn Cem — DATE OF BURIAL: 11-13 1923

20 UNDERTAKER: Geo. A. Gibson — ADDRESS: 1733 W. Lanvale

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80750

CERTIFICATE OF DEATH.

57 D 80750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 S. Charles ST., 73 WARD)

2-FULL NAME Catherine J. Mack

(a) RESIDENCE NO. 1107 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John Mack

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Robert Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Mack (Son)

(Address) 1107 S. Charles

15 Filed ..... 19 ..... Registrar

NOV 1 21923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov. 1, 1923,

that I last saw h[illegible] alive on Nov. 1, 1923,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) diabetes mellitus

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O'Donnell, M. D.

Nov 1, 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Nov. 3 1923

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80751

CERTIFICATE OF DEATH.

75-08 80751

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 108 Ellamont ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington Taylor

(a) RESIDENCE. NO. 108 Ellamont ST. 70 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Nancy Taylor

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE — Years: 66 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ala

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John F. Taylor (Address): 108 Ellamont

15 Filed ..... 19..... Registrar

NOV 13 1923 ROBERT H. KRAMER CHIEF CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from about Nov, 1923, to Nov 11, 1923, that I last saw h[illegible] alive on Nov 9, 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Left Lower Plegia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Knell, M. D.

Nov, 1923 (Address) Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] DATE OF BURIAL: 11/13 1923

20 UNDERTAKER: James A. Lewis ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 80752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80752

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 434 E Randall St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin G. Klein

(a) Residence No. 434 E Randall St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Klein

6-DATE OF BIRTH (month, day and year) July 4 1858

7-AGE. 65 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Garage Work

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, John R Klein

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14-

(Informant) Annie E Klein

(Address) 434 E Randall St

15-

Filed....., 19?

Registrar.

NOV 13 1923

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-9-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 19 23 to Nov 9 19 23

that I last saw h.. alive on Nov 9 19 23

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E Whelle M. D.

11/10, 1923 (Address) 1279 William St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	11-13, 1923
20-UNDERTAKER.	**ADDRESS**
E & B Hoke	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 80753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-007 D 80753

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 902 Elm Place ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James R. Custis

(Residence in Baltimore: No. 902 Elm Place St.: 17 yrs. 3 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If wife, the word): Single

6 DATE OF BIRTH: September (Month) ..... (Day) , 1906 (Year)

7 AGE: 17 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: at School (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Custis

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Carrie Wade

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Custis

(Address) 902 Elm Place

NOV 13 1923

Filed ..... , 191 ROBERT R. KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November (Month) 10 (Day) , 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923 to Nov 10 1923 that I saw [illegible] alive on Nov 9, 1923 and that death occurred, on the date stated above, at 11 a m. The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. 3 mos. 10 ds.

Contributory (SECONDARY) Anaemia of unspecified origin

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Strawbridge M. D.

Nov 13, 1923 (Address) 1202 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Nov 17, 1923

20 UNDERTAKER: Accomac — ADDRESS: 1172 [illegible]

John H. Toadvine Va

Cor.—1-12-23—M&T—100 Bks.

D 80754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 15th St near Ohio (St.) 20th (Ward)

REGISTERED NO. 188-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ousky

(a) RESIDENCE No. 4620 First Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Ousky

6 DATE OF BIRTH (month, day, and year) July 15/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) Slovania

PARENTS

10 NAME OF FATHER Thos Ousky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Slovania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Slovania

14 Informant Mrs Anna Ousky
(Address) 4620 First Ave

15 Filed ... 1923 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Struck Street Car

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

Nov 12 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 11/13 1923

20 UNDERTAKER Stephen J. Fralinger

ADDRESS 1000 E. Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80755

91-00 80755

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Cameron

(a) Residence No. Preston & Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Russell

6-DATE OF BIRTH (month, day and year) July 2, 1853

7-AGE. 70 yrs. 4 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mining Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country).

PARENTS.

10-NAME OF FATHER, Donald Cameron

11-BIRTHPLACE OF FATHER (city or town) Scotland
(State or Country).

12-MAIDEN NAME OF MOTHER Catherine Murphy

13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country).

11- (Informant) Sisters of the Poor

(Address) Preston & Caroline

15-

Filed..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-12-1923

17- I HEREBY CERTIFY, That I attended deceased from 11/8 1923 to 11-12 1923.

that I last saw h. alive on 11-11 1923

and that death occurred, on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wells M. D.

11/12 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL. Nov 13 1923

20-UNDERTAKER. J. Wm Cook

ADDRESS 307 E North Ave

ROBERT R. KRAUTER

NOV 1 01923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80756 — 80756

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Homewood Hospital St. Charles St. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Alberta Anderson

(a) RESIDENCE. NO. 702 W. North ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

064

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jesse N. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth J. Comeigne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. O. Anderson

(Address) 901 Lennox St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to Nov. 11, 1923, that I last saw h[illegible] alive on Nov. 10, 1923, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Breast

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. H. Pennebaker, M. D.

. 19 (Address) 209 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery — DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-003 D 80757

D 80757

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E Pratt ST., V WARD)

2-FULL NAME Augusta Snow

(a) RESIDENCE NO. 1822 E Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of C. F Snow

6 DATE OF BIRTH (month, day, and year) May 14 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Anton Quatmann

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Contonia Victoria

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Amelia Krueger

(Address) 1822 E Pratt St.

15 Filed NOV 7 1923, 19 ..... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to Nov 10, 1923,

that I last saw h[illegible] alive on Nov 10, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Exhaustion

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. L. Sage, M. D.

Nov 11, 1923 (Address) 919 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto

DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Hoffman St

NOV 7 1923 ROBERT R. KRAUTER Registrar of Vital Records

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80758

CERTIFICATE OF DEATH.

29 D 80758

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 946 Harford Ave St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Colford

(a) Residence No. 946 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): Mar 5. 1868

7-AGE: 55 yrs. 7 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Patrick Colford

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Ellen Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-Informant: Mrs Margaret Hitchcock

(Address): 946 Harford Ave

15-

Filed....., 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 5. 1923

17- I HEREBY CERTIFY, That I attended deceased from 11/7, 1923, to 11-4, 1923, that I last saw h.e alive on 11-9, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chr. interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) W. Thomas Goss, M. D.

11/11, 1923 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov. 13. 1923

20-UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80759 46 D 80759

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S Wallas St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Jackson

(Residence in Baltimore: No. 117 S. Wallas St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, unknown (Month), (Day), 1867 (Year)

7-AGE, approx 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Jacksonville Fla.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Smyth (friend)

(Address) 117 S Wallas St

15-

NOV 13 1923

ROBERT R. KRAUTER, Burial Permit Clerk

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1923, to Nov 1923, that I saw h e alive on Nov. 9 1923, and that death occurred, on the date stated above, at 3 00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

6 days

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R J Young M. D.

11/12, 1923 (Address) 1429 Harlem

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet cemetery

DATE OF BURIAL, Nov. 13 1923

20-UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80760

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE (No 415 N. ANN St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Goldstein

(a) Residence No 415 N. Ann Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Goldstein

6-DATE OF BIRTH (month, day and year)

7-AGE. 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS

10-NAME OF FATHER Alexander Goldstein

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Bessie —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

11-

(Informant) Jack Levin

(Address) 1439 E. Balto St

15-

Filed ..... 192.....

Registrar.

NOV 13 1923 ROBERT R. KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-12-23

17- I HEREBY CERTIFY, That I attended deceased from 11/9/23, 19..... to 11/12, 1923, that I last saw h. /A alive on 11/12 1923, and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

11/12, 1923 (Address) 1826 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, 11/13, 1923

20-UNDERTAKER, Jack Levin ADDRESS 1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 30761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 30761

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 N Broadway ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth V. Taylor

(a) RESIDENCE NO. 1051 N Broadway ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Taylor

6 DATE OF BIRTH (month, day, and year): March 30 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Elizabeth Hemming

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Elizabeth Taylor Daughter 1051 N. Broadway

15 Filed ..... 19 ..... Registrar

NOV 13 1923 ROBERT R. KRAUSER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Nov 12, 1923, that I last saw her alive on Nov 11, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Kenton, M. D.

11/21/1923 (Address) 709 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov 13 1923
20 UNDERTAKER	ADDRESS
D Henry Lutz	N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 80762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D 80762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., No WARD)

2-FULL NAME Mary Connelly

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ppo

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Record
(Address)

15 Filed NOV 13 1923, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1923, to Nov. 11, 1923, that I last saw her alive on Nov. 11, 1923, and that death occurred, on the date stated above, at 10^20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) ? yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Bruce, M. D.

11-12, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Cemetery	Nov 14 1923
20 UNDERTAKER	ADDRESS
Robt. J. Turner Sons	1442 W Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80763

CERTIFICATE OF DEATH.

90D 80763

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1349 Lanes ST., 21 WARD)

2-FULL NAME John Kaelter

(a) RESIDENCE (No.) 1349 Lanes ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed~~, or Divorced, ~~(write the word)~~: Widower

5a If married, widowed, or divorced, (HUSBAND of or) WIFE of: the late Emma Kaelter

6 DATE OF BIRTH (month, day, and year): Oct 23 1858

7 AGE — Years: 63 — Months: — — Days: 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Carriage Iron Works

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Kaelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Mary Keyser

(Address): 1349 Lanes St

15 Filed ..... 19 ..... Registrar

NOV 1 1923 ROBERT R. KRAUTER, Chief Bureau Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Nov 11, 1923, that I last saw h alive on Nov 10, 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? .. Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harry Boyd M. D.

11-12 1923 (Address) 602 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: Jos Sourdens Son — ADDRESS: 217 S. Bond

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80764 (duplicate) D 80764

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 1 N Broadway ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Scott

(a) RESIDENCE NO. 802 E 22nd (Parents) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 day How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Church Home - Infirmary Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Caither Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Mildred Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Geneva, NY

14 Informant Mildred Scott (Mother)
(Address) 802 E. 22nd St. Balto. Md.

15 Filed ROBERT R. KRAUTER. Registrar

NOV 1 31923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Nov 11, 1923, that I last saw h/N alive on Nov 11, 1923, and that death occurred, on the date stated above, at 8.50 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

5 months miscarriage

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Premature separation of Placenta (duration) yrs. mos. 1 day

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Joseph Thomas Carothers M. D.

, 19 (Address) Church Home and Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Unitarian Laboratory Johns Hopkins

DATE OF BURIAL 19

20 UNDERTAKER Medical School Baltimore Md.

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80765

CERTIFICATE OF DEATH.

90 D 80765

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2410 Francis ST.: 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry. Ambrose.

(a) RESIDENCE. No. 2410 Francis ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lottie Ambrose

6 DATE OF BIRTH (month, day, and year) April 4th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Tel. Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George W. Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Eichler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila

14 Informant Lottie Ambrose. (Address) 2410 Francis St.

15 Filed NOV 13 1923, 19.. ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923 to Nov 9, 1923, that I last saw h[im] alive on Nov 9, 1923, and that death occurred, on the date stated above, at 11 50 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Jesse Talbot, M. D.

11/12, 1923 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Lea Cemetery Hagerstown Md.	Nov 13th 1923

20 UNDERTAKER Leo S. Cook

ADDRESS North Branford

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 80766

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 Greenmount Ave 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas F. Minton

(a) Residence No. 1042 Greenmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth Minton

6-DATE OF BIRTH (month, day and year) June 6 1859

7-AGE, 64 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Regger

(b) General nature of industry, business, or establishment in which employed (or employer). D. Bruce & Harvey

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. Thomas Minton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER. Not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). not know

14- (Informant) Letitia Minton

(Address) 861 Greenmount Ave

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 12. 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Nov 11, 1923

that I last saw him alive on Nov 11, 1923

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

Nov 12. 1923 (Address) 1512 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. Nov 15, 1923

20-UNDERTAKER. E. W. Conklin ADDRESS 924 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

80767

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

80767

REGISTERED No. C 129

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 308 Albemarle St. 3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura De Cicco

(Residence in Baltimore: No. 308 Albemarle St St. 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown, 1874 (Month) (Day) (Year)

7 AGE: 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9 BIRTHPLACE (State or country): Italy

PARENTS

10 NAME OF FATHER: Michael Coricaru

11 BIRTHPLACE OF FATHER (State or country): Italy

12 MAIDEN NAME OF MOTHER: Anna Jemina

13 BIRTHPLACE OF MOTHER (State or country): Italy

14 THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) Cosima Decicca

(Address) 308 Albumale St

15

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 11, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1922, to Nov. 10 1923, that I saw h[illegible] alive on Nov. 10, 1923, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 6 mos. ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Stanton McAleer M. D.

....., 191.... (Address) 1609 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Nov 14 ....19 23

20 UNDERTAKER: Martin Depple

ADDRESS: 37 Lamm St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80768

CERTIFICATE OF DEATH.

161-001

D 80768

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Hunter ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Franke

(a) RESIDENCE. No. 814 Hunter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19 23, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 13 1923

20 UNDERTAKER: Smith & Wack & Son — ADDRESS: 1916 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&D 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1325 D 80769

CERTIFICATE OF DEATH.

X100-001 D 80769

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Reed

(a) RESIDENCE No. Newark, Del Box 81 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Del.

PARENTS

10 NAME OF FATHER: James Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER: Emma Emerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Record
(Address): John Hopkins Hosp

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1923, to Nov 13, 1923.

that I last saw him alive on Nov 13, 1923.

and that death occurred, on the date stated above, at 4:40 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary): Benign Prostatic Hypertrophy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov. 7

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles G. Bagley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Newark Del. — DATE OF BURIAL: Nov 13 1923

20 UNDERTAKER: W. J. Tickner & Sons — ADDRESS: North Ave

NOV 15 1923 ROBERT R. KRAUTER Burial Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Groeery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80770

CERTIFICATE OF DEATH.

D 80770

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellis

(a) Residence No. 340 N. Poplin St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Sam Ramson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Sarah Carter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- Municipal Hospital Record (Informant)

(Address)

15- Filed 192 Registrar.

ROBERT R. KRAUTER

NOV 1 1923

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from October 27 19 23 to November 3 19 23

that I last saw h.. alive on November 2 19 23

and that death occurred, on the date stated above, at 8:35 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Primary of Cervix - general metastasis)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fields M. D

11-9 - 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. 11/3 1923

20-UNDERTAKER, John Powers ADDRESS 537 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80771 ✓ 38 D 80771

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. General Hospital South Baltimore St. 24 Ward)

2-FULL NAME William Newman.

(a) RESIDENCE NO. 1110 Peters Ave New Orleans La. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of May King (Deceased)

6 DATE OF BIRTH (month, day, and year) May 6-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Owner &c

(b) General nature of industry, business, or establishment in which employed (or employer) Horse Racing.

(c) Name of employer

9 BIRTHPLACE (city or town) New Orleans La.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Newman

11 BIRTHPLACE OF FATHER (city or town) Tipperary
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannorah Hickey

13 BIRTHPLACE OF MOTHER (city or town) Tipperary
(State or country) Ireland

14 Informant Edw Newman
(Address) 2126 Prytania St New Orleans La

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12th 23

17 I HEREBY CERTIFY, That I attended deceased from November 7 1923 to November 12 1923.

that I last saw him alive on November 12 1923

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Tertiary Syphilis

(duration) 40 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Symptomatology

(Signed) L. L. Bruns, M. D.

11/12 1923 (Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Orleans La

DATE OF BURIAL 11/16 1923

20 UNDERTAKER J. J. Tobin & Sons

ADDRESS 13 Bienville

NOV 23 1923 CLERK

Spec.—1-10-21—M&T—1500 Bks.

D 80772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80772

74-004

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, note statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632. Gorsuch ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mc Laughlin

(a) RESIDENCE NO. 1632. Gorsuch ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late. Mathew Laughlin

6 DATE OF BIRTH (month, day, and year): 5/15/1843.

7 AGE: Years 80 Months 5 Days 27 If LESS than 1 day, ~~hrs.~~ or ~~min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: John Carroll.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: M. Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Anna Mc Laughlin

(Address) 1632. Gorsuch ave.

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/11/23 19

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Nov 11, 1923,

that I last saw ~~him~~ alive on Nov. 10, 1923,

and that death occurred, on the date stated above, at 9. a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Prentiss, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: Geo. - L. Ruth

ADDRESS: 1735 Harford ave.

NOV 3 1923

Robert P. Harrison,
Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal Cerebral Haemorrhage

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80773

187-D 80773

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (ST.) (WARD)

2-FULL NAME Andrew R. Ortt

(a) RESIDENCE NO. 3921 Foster ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 28/1914

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
9	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Ortt

11 BIRTHPLACE OF FATHER (city or town) Balto Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Dorn

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. Md
(State or country)

14 Informant Charles Ortt
(Address) 3921 Foster ave

15 Filed ..... 192 .....
Registrar

NOV 14 1923
Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fell against handle of fly wheel

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Nov 12, 1923 (Address) Curtis Bay Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Nov. 14 1923

20 UNDERTAKER Tully and Zeile ADDRESS 403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80774 ✓ D 80774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Christ Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor St ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Allders

(a) RESIDENCE NO. ..... Chase Maryland ST., WARD Chase Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 1920

7 AGE — Years 3 — Months 1 — Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Chase Md

PARENTS

10 NAME OF FATHER William Allders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chase

12 MAIDEN NAME OF MOTHER Susie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chase

14 Informant (Address) James Potts Chase Md.

15 Filed NOV 13 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 12, 1923 to November 12, 1923.

that I last saw him alive on November 12, 1923.

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Chase, Md.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Dr. L. W. Kennard M. D.

11-12, 1923 (Address) 704 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chase Sharp St M E Church

DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Barnes & Edgehill Balto Cary

ADDRESS .....

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and old state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80775

CERTIFICATE OF DEATH.

REGISTERED NO. 83

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1137 E Lafayette St., Ward)

2-FULL NAME Bertha G Gunter

(a) RESIDENCE NO. 1137 E Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If ~~married, widowed, or divorced~~ HUSBAND of or WIFE of Herman G. Gunter

6 DATE OF BIRTH (month, day, and year) Oct 1850

7 AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Frederick

PARENTS

10 NAME OF FATHER Fred Schild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Kuon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Herman G Gunter

(Address) 1137 E Lafayette

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Nov 12, 1923, that I last saw her alive on Nov 11, 1923, and that death occurred, on the date stated above, at 4.35 a.m.

The CAUSE OF DEATH* was as follows:

cerebral softening

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D Strauchen, M. D.

, 19 (Address) 301 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dacks Cemetery Dec

DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Robt Johnson

ADDRESS 1442 W Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 31923 [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80776

CERTIFICATE OF DEATH.

101-001

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 McCulloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Lee

(a) Residence No. 1834 McCulloh St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 25. 1848

7-AGE. 75 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) ..... (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, Randolph Lee

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Sarah Lee

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Va

11- (Informant) Jennie Lee

(Address) 1834 McCulloh St

13- Filed NOV 13 1923 192.. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-12-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 3, 1923 to Nov 12 1923

that I last saw h— alive on Nov 8 1923

and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH was as follows: Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys. & Exam.

(Signed) R. Garland Dennell M. D.

Nov 13, 1923 (Address) 1934 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Pimlico Cemetery DATE OF BURIAL 11/14 1923

20-UNDERTAKER Saml D Hensley ADDRESS 578 N Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 80777

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓ D 80777

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Linden Ave ST., 11 WARD)

2-FULL NAME Geo. E. Frey

(a) RESIDENCE NO. 1018 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sydney Jane Frey (wife)

6 DATE OF BIRTH (month, day, and year): July 11 - 1863

7 AGE: Years 60 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Caterer

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Richard Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Louisa Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll County

14 Informant (Address): Sydney Jane Frey (wife) 1018 Linden Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1923, to Nov 11th, 1923, that I last saw h[illegible] alive on Nov 10th, 1923, and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(2nd Stroke)

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Hardening

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

19 (Address) 607 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leland Cem

DATE OF BURIAL 11/15 1923

20 UNDERTAKER: Samuel Hawley

ADDRESS 528 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOV 21 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80778

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2911 Dona Terrace St.: 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Lindenberger

(a) RESIDENCE. No. 2911 Dona Terrace St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John E Lindenberger

6 DATE OF BIRTH (month, day, and year) May 11th 1863

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	60	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John Stamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva M Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eva M M Soldekle (Address) 2911 Dona Terrace

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923, to Nov 13, 1923, that I last saw her alive on Nov 12, 1923, and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic arthritis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Donaldson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Lutheran Cemetery	Nov 15th 1923

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument

NOV 13 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30779 D 30779

CERTIFICATE OF DEATH.

10

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital, ST., WARD)

2-FULL NAME Frances Webb.

(a) RESIDENCE NO. 4620 O'Donnell ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Webb

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mary Webb
(Address) 4620 O'Donnell St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1923, to Nov 13, 1923, that I last saw him alive on Nov 13, 1923, and that death occurred, on the date stated above, at 7:40 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal.

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B. McGowan M. D.

11/13/23 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Nov. 14 1923

20 UNDERTAKER Zirkler & Zirkler ADDRESS 1739 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOV 13 1923

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 80780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80780

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 429 Whitridge Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Harry George Burke

(a) Residence No. 429 Whitridge Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Isabelle V Burke

6-DATE OF BIRTH (month, day and year): Mar 4 1884

7-AGE: 39 yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Estimator on Interior Home Decoration
(b) General nature of industry, business, or establishment in which employed (or employer): Stewart & Co
(c) Name of employer:

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry D. Burke

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Louisa Wolbrab

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto Md.

14- (Informant) Isabelle V. Burke
(Address) 429 Whitridge Ave

15- Filed..... 19?..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 15-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8 19 23 to Nov 15 19 23

that I last saw him alive on Nov. 1 19 23

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration)..... yrs..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Sanderson M. D.

, 19 (Address) 1714 N Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 15 19 23

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 21 1923

Spec.—1-10-21—M&T—1500 Bks.

D 80781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80781

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 3 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Roberts

(a) RESIDENCE NO. 312 S. Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Roberts

6 DATE OF BIRTH (month, day, and year) ? 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Hortman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louisa Teichman

(Address) 303 E Curley St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 1923 to Nov 12 1923

that I last saw her alive on Nov 12 1923

and that death occurred, on the date stated above, at 8:00 A m.

The CAUSE OF DEATH* was as follows:

Colles' Fracture Left Wrist

Fracture neck Right Femur

(Over)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J Norwood Mercer, M. D.

..... 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL 1/00/14 1923

20 UNDERTAKER Peter Nicolaus

ADDRESS 2000 Eastern

NOV 13 1923 Robert F. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80782 D 80782

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) (Ward) 17

2-FULL NAME John (James) Dent

(a) RESIDENCE NO. 578 Munsen st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpentar

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Horris Dent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M. T. H.

15 Filed NOV 31 1923, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1923 to Nov. 12, 1923.

that I last saw him alive on Nov. 12, 1923.

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

11-12, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11-15 1923

20 UNDERTAKER David Easton

ADDRESS 916 Gay ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80783

D 80783

CERTIFICATE OF DEATH.

101-80

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 827 Sarah Ann ST., 18 WARD)

2-FULL NAME Billie Wright

(a) RESIDENCE NO. 827 Sarah Ann ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: Lewis Wright

6 DATE OF BIRTH (month, day, and year): — — 1881

7 AGE: Years 42 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lewis Wright

(Address) 827 Sarah Ann St.

15 Filed ..... 19 ..... Registrar

NOV 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923 to November 10, 1923, that I last saw her alive on November 10, 1923, and that death occurred, on the date stated above, at 4.10 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Howell Jr., M. D.

, 19 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11-14-19 23

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Ea on

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR [illegible]

Spec.—1-10-21—M&T—1500 Bks.

STALFORT.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80784

D 80784

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Pulaski ST., 20 WARD)

2-FULL NAME John H. Stalfort

(a) RESIDENCE NO. 516 N. Pulaski ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Medora Stalfort

6 DATE OF BIRTH (month, day, and year): Sept. 16-1838

7 AGE — Years: 85 — Months: 1 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carriage Business

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 20 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frederick Stalfort

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Augusta M. Eberley (Address) 16 Evans & Chapel Road

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th, 1923, to Nov 11th, 1923, that I last saw h[illegible] alive on Nov 10th, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Usual symptoms

(Signed) H. H. Carnnel, M. D.

, 19 (Address) 1229 E Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Nov. 14 1923

20 UNDERTAKER: Horace A. Burgee — ADDRESS: 363 Fallsld.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING: RESERVED FOR OFFICIAL USE ONLY

NOV 13 1923

Burial Permit Clerk.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-002 D 80785

11 80785

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 711 Tessier St. St.: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Bernard West.

(Residence in Baltimore: No. 711 Tessier St St.: Life yrs. mos. ds.)

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: July (Month) 1 (Day), 1892 (Year)

7 AGE: 32 yrs. 4 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Race-track Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Nicholson

11 BIRTHPLACE OF FATHER (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mamie West

13 BIRTHPLACE OF MOTHER (State or country): Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mamie West (Mother)

(Address) 711 Tessier Street

15

Filed ....., 191 .....

Robert P. Harrison, Registrar

Burial Permit Clerk

NOV 3 1923

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November (Month) 11 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 12 1923. to. November 11 1923 that I saw him alive on November 10, 1923. and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy, (non-venereal).

(Duration) 0 yrs. 0 mos. 8 ds

Contributory (SECONDARY) Bronchitis, chronic

(Duration) 9 yrs. 1 mos. 10 ds.

(Signed) John C. Stansbury M. D.

Nov 12, 1923 (Address) Balto. Gen'l Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Nov. 14, 1923

20 UNDERTAKER: Jas. M. Johnson

ADDRESS 1369 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80786

CERTIFICATE OF DEATH.

38 D 80786

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Brunt ST. 14 WARD)

2-FULL NAME Ernestine Coffier

(a) RESIDENCE NO. 1405 Brunt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Coffier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Elnora Copeland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Benjamin Coffier
(Address) 1405 Brunt St

15 Filed NOV 13 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6th, 1923, to Nov. 12th, 1923,

that I last saw her alive on 10th, 1923,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Anuria

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Eclampsia (duration) Days mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

11/13, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Jno. W. Johnson — ADDRESS 1329 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—10M—15[illegible]ks.

167305 Grzeskowiak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80787 21 D 80787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hosp

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.....) ST.,..... (WARD)

2-FULL NAME James Gryeskowiak Greszkowiak

(a) RESIDENCE NO. 2400 Fleet St ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 4, 1923

7 AGE: Years — Months 4 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Gryeskowiak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Kalandek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Record

(Address): John Hopkins Hosp

15 Filed NOV 14 1923, 19..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1923, to Nov 13, 1923, that I last saw him alive on Nov 13, 1923, and that death occurred, on the date stated above, at 3 9. m.

The CAUSE OF DEATH* was as follows:

Congenital Inguinal Hernia

(duration) yrs. 3 mos 19 ds.

CONTRIBUTORY (Secondary) (3) Otitis Media Acute (2) Erysipelas 14da

(duration) yrs. (1) (2) mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Oct 24 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bugg, M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80788

100-001

D 80788

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1740 Webster ST.: 24 WARD)

2-FULL NAME Charles Edw. Norton

(a) RESIDENCE. No. 1740 Webster ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 8 1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Norton Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Marie Sommer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Father

(Address): 1740 Webster St.

15 Filed . . 19 Registrar

ROBERT R. KRAUTER.

NOV 14 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 . 1923 . to Nov 12 . 1923 .

that I last saw h she alive on Nov 12 . 1923 .

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Weber, M. D.

11/13 1923 (Address) 1803 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sweetz cem — DATE OF BURIAL: Nov 14 1923

20 UNDERTAKER: John A. Weber — ADDRESS: 1803 Bank St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 80789

CERTIFICATE OF DEATH.

90 D 80789

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1829 Ashland avenue St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Burley

(a) Residence No. 1829 Ashland Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or) WIFE of Mildred Burley

6-DATE OF BIRTH (month, day and year) 1861

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Preacher

(b) General nature of Industry, business, or establishment in which employed (or employer)..... M.E.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Virginia

PARENTS.

10-NAME OF FATHER Edw Burley

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va

12-MAIDEN NAME OF MOTHER, Delta —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va

14- (Informant) Mildred Burley

(Address) 1829 Ashland Ave.

15- Filed NOV 14 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/12/1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to Nov 12, 1923, that I last saw h— alive on Nov 12, 1923, and that death occurred, on the date stated above, at 1.25a m.

The CAUSE OF DEATH* was as follows: Cardiac Renal Calculus

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cys Pleurisy

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. H. Flowers M. D.

Nov 12, 1923 (Address) 1145 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	Nov 15 1923
20-UNDERTAKER, John H. Toadvine	ADDRESS 142 Uniform St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 80790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162

D 80790

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hosp.

CITY OF BALTIMORE: (No. ..... ST., 21 WARD)

2-FULL NAME Peby Boy Landon

(a) RESIDENCE NO. 836 Washington Blvd ST. Lmard WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
—	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER C. L. Landon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Welling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clarence L. Landon

(Address) 836 Washington Blvd

15 Filed ..... 19 ..... Registrar

NOV 14 1923 ROBERT J. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 13, 1923, that I last saw him alive on Nov. 13, 1923, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Hemophilia.

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 10/13/23.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Hovey M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Nov 14 23

20 UNDERTAKER Wm. J. Ickes & Sons ADDRESS Norfolk

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80791

CERTIFICATE OF DEATH.

25 31

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Belvidere Ave. & Charles St., Ward) Lakeland, Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William A. T. Wright

(a) Residence No. Belvidere Ave. & Charles St., Lakeland, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 3 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 7, 1895

7-AGE.	If LESS than 1 day.
28 yrs. 4 mos. 4 ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clothing Cutter

(b) General nature of Industry, business, or establishment in which employed (or employer). 80

(c) Name of employer. 0

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER Henry C. Wright

11-BIRTHPLACE OF FATHER (city or town). Richmond
(State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Mary Elizabeth Bankard

13-BIRTHPLACE OF MOTHER (city or town). Baltimore
(State or Country). Maryland

14- (Informant). Mr. Louis Blumenauer
(Address). Belvidere Ave. & Charles St. Lakeland, Md.

15-
Filed NOV 14 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to Nov 11, 1923, that I last saw him alive on Nov 10, 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) Unknown

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary Oedema (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Mitch, M. D.

11-12-1923 (Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Nov 15, 1923

20-UNDERTAKER. Joseph B Cook

ADDRESS 1003 W Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 80792

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Bruce ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Spence

(a) RESIDENCE. NO. 1533 Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lindon

6 DATE OF BIRTH (month, day, and year): Jenkins

7 AGE — Years: 45 — Months: 7 y's — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): House cleaning

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: A F Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Martha Willey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Virgie Brooke
(Address) 1461 N Ca 274

15 Filed ..... 19 .....
Registrar

NOV 14 1923 ROBERT N. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Nov 11, 1923, that I last saw h alive on 11/11, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1533 Bruce St

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boynton, M. D.

, 19 (Address) 1618 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville

Apus Wharf Northumberland

DATE OF BURIAL: 11/14

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 2319 Division St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80793

CERTIFICATE OF DEATH.

57 D 80793

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp ST.: 8 WARD)

2-FULL NAME Catherine Baird.

(a) RESIDENCE NO. 1717 Lansing Ave ST.: ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Volk

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Catherine Steilman

(Address) 1520 N. Post St

15 Filed NOV 14 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1923, to Nov 12, 1923, that I last saw her alive on Nov 12, 1923, and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Ventral Hernia.

— 10 hrs
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus ?
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-11-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Monnaget, M. D.

11-12, 1923 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: Nov. 15 1923

20 UNDERTAKER: Henry Horch Son | ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80794

101-001 B 80794

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME James Bucher Williams

(a) RESIDENCE NO 711 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jacksonville Fla.

12 MAIDEN NAME OF MOTHER Carmille Thorton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Ga.

14 Informant Mrs. J. Brooks
(Address) Fairfield Md.

15 Filed ....., 192 ..... Registrar

OCT 14 1923 ROBERT R. KRAMER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Rt. Lung)

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Collins, M. D.
(Coroner.)

Nov 14 23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn — DATE OF BURIAL nov 11 1923

20 UNDERTAKER R C Gross — ADDRESS 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80795

CERTIFICATE OF DEATH.

124 D 80795

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) Monument st. - ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Emanuel Goetz

(a) RESIDENCE NO. 2524 Madison ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Goetz

6 DATE OF BIRTH (month, day, and year): Oct. 31, 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Greif Bros.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Lipman Goetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Addie Goetz

(Address) 2524 Madison Ave

15 Filed ... 19... Registrar

ROBERT R. KRAUTER, NOV 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/13 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/6/23, 1923, to 11/13/23, 1923, that I last saw him alive on 11/13/23, 1923, and that death occurred, on the date stated above, at 5:40 p m

The CAUSE OF DEATH* was as follows:

Intestinal perforation following cholecystostomy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Chr. Bronchitis + Emphysema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/6/23

Was there an autopsy? Yes

What test confirmed diagnosis? clinical + autopsy

(Signed) Isidor I. Levy, M. D.

Nov 14 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 11/15/1923.

20 UNDERTAKER: David Sondheim

ADDRESS: 1820 Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80796

CERTIFICATE OF DEATH.

100-001 D 80796

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 15 WARD)

*(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Bowers

(a) RESIDENCE NO 1652 N. Smallwood st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 11 mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Blank

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Louis Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lillian Abrams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Father 1652 N Smallwood st Hebrew

15 Filed ..... 19 ..... Registrar

NOV 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1923, to Nov 13, 1923, that I last saw her alive on Nov 13, 1923, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Br. Pneumonia & Emfysema & Strep. Septicemia

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) 1 yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bl Culture

(Signed) Cora C. Alter, M. D.

11/13 1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Washington Rd

DATE OF BURIAL 11/14 1923

20 UNDERTAKER A. L. Levinson & Bro

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80797

CERTIFICATE OF DEATH.

47 ✓ D 80797

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Blair Road ST. 26 WARD)

2-FULL NAME Julia E. Stugel

(a) RESIDENCE NO. 921 Blair Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Stugel

6 DATE OF BIRTH (month, day, and year) Mar. 14, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER James Buhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Geraldine Turnbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Louis Stugel (Address) 921 Bolton St.

15 Filed ....., 19 ..... Registrar

NOV 14 1923 ROBERT R. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to Nov 12, 1923, that I last saw h2 alive on Oct 13, 1923, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) yrs. 8 mos 15 ds.

CONTRIBUTORY (Secondary) Carcinoma ~~of~~ (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ~~Do~~

Did an operation precede death? Yes Date of Aug 16-23

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Grover C Ney M. D.

, 19 (Address) 2401 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Baltimore Cemetery	Nov 14th 1923
20 UNDERTAKER	ADDRESS
C. J. Fanning & Son - 1986	Lafayette Ave

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80798

101-01 D 80798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Eastern ave. WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Withowski

(a) RESIDENCE NO. 2207 Eastern ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Withowska

6 DATE OF BIRTH (month, day and year) Nov 5 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	56		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Withowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Withowski jr (Address) 2207 Eastern av

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Nov 11, 1923,

that I last saw h[illegible] alive on Nov 11, 1923,

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] Insley, M. D.

11 19 (Address) 2138 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Nov 15 1923

20 UNDERTAKER Wendell Dippel & Son — ADDRESS 378 Hmn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80799 — 10

CERTIFICATE OF DEATH.

B 80799

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1751 E Preston St. 8 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Theodore Wissel

(a) RESIDENCE. NO. 1751 E Preston St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): March 9-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Wissel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana

12 MAIDEN NAME OF MOTHER: Charlotte M Schoenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

11 Informant (Address): Harry. Wissel. 1751 E Preston St

15 Filed . 19 . Registrar

NOV 14 1923 ROBERT R. KRAUTER Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1923 to Nov 13 1923, that I last saw h[illegible] alive on Nov 13 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

CONTRIBUTORY (Secondary): Absorption of Toxine Natural (duration) yrs. mos. 4 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Cook, M. D.

(Address) 4134 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer.	Nov 14th 1923
20 UNDERTAKER	ADDRESS
Leo D. Cook	North & Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80800

CERTIFICATE OF DEATH.

101-001

D 80800

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519 Old York Road ST., 9 WARD)

2-FULL NAME August Weil

(a) RESIDENCE No. 3519 Old York Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Geraldina Weil

6 DATE OF BIRTH (month, day, and year) Mar 24/53

7 AGE: Years 68 Months 7 Days 14 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Window Glass

(b) General nature of industry, business, or establishment in which employed (or employer): Blower

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Weil

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant August Weil Jr.

(Address) 3519 Old York Road

15 Filed ..... 1923 Registrar

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from November 3, 1923, to November 13, 1923, that I last saw h~~im~~ alive on November 13 1923 and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray Examination

(Signed) Clarence Peter M. D.

, 19 (Address) 451 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 15 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 30801 — 31 B 30801

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Washington ST., W WARD)

2-FULL NAME Andrew Engle

(a) RESIDENCE NO. 103 S Washington ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Dora Engle

6 DATE OF BIRTH (month, day, and year) July 10-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 163

(b) General nature of industry, business, or establishment in which employed (or employer) Painting

(c) Name of employer Md Color Printing Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dora Engle (Address) 103 S Washington St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7 1923 to Nov 12 1923

That I last saw h[illegible] alive on Nov 11 1923

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lewis M. D.

11/12/1923 (Address) 413 N Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL Nov 15 1923

20 UNDERTAKER Philip Hennig — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

K D 80802 — 90 D 80802

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1904 Park Ave ST., 13 WARD)

2-FULL NAME Elizabeth Schaefer

(a) RESIDENCE NO. 1904 Park Ave ST., 13 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? 71 yrs. 5 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan - 5 - 1862

7 AGE — Years: 71 — Months: 5 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John C. Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Germany

12 MAIDEN NAME OF MOTHER: Mary Einer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Germany

14 Informant (Address): Mrs Mary V. Carr (sister) 1908 Park Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15th, 1923, to Nov. 12th, 1923, that I last saw her alive on Nov. 12th, 1923 and that death occurred, on the date stated above, at 7:55 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis with mitral insufficiency, several years.

(duration) X yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 7 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Edward C. Price, M. D.

11-12, 19 23 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov 15 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS: 108 W. NORTH AVE.

NOV 14 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

K D 80803 CERTIFICATE OF DEATH. 100-001 D 80803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2122 St. Paul ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

2-FULL NAME John Francis Hancock

(a) RESIDENCE NO. 2122 St Paul ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 89 yrs. 2 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Frances A. Hancock

6 DATE OF BIRTH (month, day, and year): Sept-9-1834

7 AGE — Years: 89 — Months: 2 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfg Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer): Medicines

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Maryland.

PARENTS

10 NAME OF FATHER: John Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country): ??? Maryland

12 MAIDEN NAME OF MOTHER: Mary Leeke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ??? Maryland.

14 Informant: Jas. E. Hancock-(Son)

(Address) 2122 St. Paul St

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

NOV 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1923, to Nov 12, 1923, that I last saw him alive on Nov 12, 1923 and that death occurred, on the date stated above, at 8.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Old age —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Watson, M. D.

Nov 13, 1923 (Address) 2128 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov-15 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. E... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSI... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

K D 80804 90 ✓ D 80804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416-W-Pratt ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

2-FULL NAME Sophie Edeler Hellwig

(a) RESIDENCE NO. 416-W-Pratt ST., 4 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Justus W. Hellwig

6 DATE OF BIRTH (month, day, and year): Oct-27-1839

7 AGE — Years: 84 — Months: 0 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): unknown (State or country): Germany

PARENTS

10 NAME OF FATHER: Carl Edeler

11 BIRTHPLACE OF FATHER (city or town): unknown (State or country): Germany

12 MAIDEN NAME OF MOTHER: Charlotte Holly

13 BIRTHPLACE OF MOTHER (city or town): unknown (State or country): Germany

14 Informant: Otto L. Hellwig (Son)

(Address) 416 W. Pratt St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12- 1923

17

I HEREBY CERTIFY, That I attended deceased from June 9- , 1920, to Nov. 12- , 1923;

that I last saw her alive on Nov. 10- , 1923.

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation, mitral regurgitation.

History — about (duration) 8 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Harold Brown, M. D.

, 19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov 15 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (William P. Mowen, Successor) — ADDRESS: 108 W. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSIC... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001

D 80805

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 21 WARD)

2-FULL NAME George W. Melchior.

(a) RESIDENCE NO. Bertram Ave - Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia W. Melchior

6 DATE OF BIRTH (month, day, and year): Nov. 5th 1876

7 AGE — Years: 47 — Months: — — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): Railways

(c) Name of employer: U. R. & E. Co.

9 BIRTHPLACE (city or town) (State or country): Balto City Maryland

PARENTS

10 NAME OF FATHER: Wm H Melchior

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Maryland.

12 MAIDEN NAME OF MOTHER: Caroline Apfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Maryland.

14 Informant: Sophie W. Melchior

(Address): Hamilton Md.

15 Filed ....., 19..... Registrar

NOV 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Nov. 12, 1923, that I last saw him alive on Nov. 12, 1923, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

(a) Myocardial Insufficiency

(duration) yrs. mos 1 hr ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) 8-10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 11-10-23.

Was there an autopsy? No.

What test confirmed diagnosis? P.S.S. and Operation

(Signed) Harold C. Pellathy M.D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov. 16, 23

20 UNDERTAKER: Fred'k Lassahn & Son — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D 80806

1-PLACE OF DEATH Found in Water at Foot of 16 St. 15 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No.)

2-FULL NAME Thomas Goodman

(a) RESIDENCE NO. 1502 Prestman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Cold	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen P. Goodman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) 11
(State or country)

12 MAIDEN NAME OF MOTHER 11

13 BIRTHPLACE OF MOTHER (city or town) 11
(State or country)

14 Informant Ellen P. Goodman
(Address) 1502 Prestman St

15 Filed NOV 14 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Foxon, M. D.
(Coroner.)

Nov 14 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL 11/14 1923

20 UNDERTAKER James H. Dunn — ADDRESS 303 Preston

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80807

CERTIFICATE OF DEATH.

100-002

D 80807

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W. Preston ST., 11 WARD)

2-FULL NAME Elizabeth Schleigh

(a) RESIDENCE NO. 17 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 19, 23,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward Schleigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edward Schleigh

(Address) 17 W Preston St

15 Filed NOV 14 1923 ROBERT A. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 8 1923. to Nov 13, 1923.

that I last saw her alive on Nov. 12, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Capillary Bronchitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchitis, marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical signs

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Martin Fuchs & Sons

ADDRESS 1827 W Balt

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80808 — D 80808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 790 W Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Smith

(a) RESIDENCE NO. 790 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Smith

6 DATE OF BIRTH (month, day and year): 6 — 1872

7 AGE: 51 (Years / Months / Days) — If LESS than 1 day, ..hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Prince George Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Caroline Collins

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Prince George Co.

14 Informant: Amanda Smith

(Address) 790 W Saratoga

15 Filed ... 19 ... Registrar

NOV 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/12/1923

17 I HEREBY CERTIFY, That I attended deceased from 11/2/, 1923, to 11/12/, 1923, that I last saw h.. alive on 11/11/, 1923, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Primal Broncho-Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(duration) Probably ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Undetermined.

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Jackson, M. D.

, 19 (Address) 808 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 11/15/23

20 UNDERTAKER: Samuel T Wensley — ADDRESS 1778 Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80809 — 31 — D 30809

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 W. Cullob ST., 14 WARD)

2-FULL NAME Lillian Jackson

(a) RESIDENCE NO. 2222 W. Cullob ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred N yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 670
(c) Name of employer: Mrs Bridon

9 BIRTHPLACE (city or town) (State or country): Middlesex Co Va

PARENTS
10 NAME OF FATHER: George Jackson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Va
12 MAIDEN NAME OF MOTHER: Alice Reed
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Alice Jackson
(Address): 2222 W. Cullob St

15 Filed ....., 19..... Registrar

NOV 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/13, 1923, to 11/12, 1923,
that I last saw h[er] alive on 11/12, 1923,
and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burt Chaffee, M. D.

11/14 1923 (Address) 2134 Druid Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 11/14 1923

20 UNDERTAKER: Saml D Hawley — ADDRESS: 778 N Bdwy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80810 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80810

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 205 Dickman St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas D. Pryor.

(a) Residence No. 205 Dickman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): June 6 1913

7-AGE: 10 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer): #35

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Geo. C Pryor.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Laura Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant): Geo C Pryor.

(Address): 205 Dickman St

15- Filed NOV 14 1923 ROBERT R. KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1923 to Nov 14 19..

that I last saw h...alive on Nov 13 19..

and that death occurred, on the date stated above, at 7 .5 A .m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. R. Campbell M. D.

Nov 14, 19 23 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Harrod & Sons	Nov 11- 14, 1923

20-UNDERTAKER.	ADDRESS
Ellis Hanke	115 E Preston St

Cor.—1-12-23—M&T—100 Bks.

D 80811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80811

1-PLACE OF DEATH In the 1500 block

CITY OF BALTIMORE, (No. 1 Mar Paleo. Av. ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Bernard O'Connor

(a) RESIDENCE NO 21 S Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva Agnes O'Connor

6 DATE OF BIRTH (month, day, and year) Mch 23 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va

PARENTS

10 NAME OF FATHER Eugene O'Connor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Tierney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14
Informant Eva Agnes O'Connor
(Address) 21 S Stricker St

15
Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)

Nov. 14, 1923 (Address) 2 S Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Nov 14 1923
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80812

CERTIFICATE OF DEATH.

10 D 80812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. First St. 26 WARD)

2-FULL NAME Catharine Fischer

(a) RESIDENCE NO. 812 S. First St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2nd 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Casper Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Margt. Lindenberger

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Casper Fischer (Address) 812 S. First St.

15 Filed NOV 14 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1923, to Nov 13, 1923, that I last saw her alive on Nov 13, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Nasal & Pharyngeal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

1923 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov 14 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

Cor.—I-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80813

CERTIFICATE OF DEATH.

+186-001 D 80813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred E. Martin

(a) RESIDENCE NO 413 E. Street, ST., Harrows Pt. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Martin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 38	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steel Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Jacob Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Julia Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Clarence Martin
(Address) 193 Blackthorn Ave, Toronto Canada

15 Filed ..., 192 ... Registrar

ROBERT R. KRAUSE
Burial Permit Clerk

NOV 14 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Surgical Shock + Injury to spine

— 18 hours
(Duration)

Struck by Engine of Canton Railroad Co

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

(Signed) Geo. H. Boston, M. D.
(Coroner.)

Nov 12 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Toronto Canada	11/16 1923
20 UNDERTAKER	ADDRESS
John F. Lakey & Sons	618 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

(Stokes)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 80814

CERTIFICATE OF DEATH.

90 D 80814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N. Bond St ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Branch Stokes

(a) RESIDENCE NO. 608 N. Bond St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Over 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Minnie Oldman
(Address) 608 N. Bond St.

15 Filed NOV 14 1923, 192 Robert P. Barrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insuffiency

(Valvular Insuffiency)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) " Leaky heart for some time

(duration) yrs. mos. ds.

(Signed) J S H Owen, M. D.
(Coroner.)

Nov 14/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Albany	Nov 16 1923
20 UNDERTAKER John W Henderson	ADDRESS 1602 E. Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 80815

HEALTH DEPARTMENT—CITY OF BALTIMORE

X101-001 D 80815

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp. St. 12 Ward)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Polzen

(a) RESIDENCE No. U.S. Marine Hospital No 1 St., ... Ward .....
(Usual place of abode) Baltimore, Md.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer S/S Ardmore

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self Hosp. Record
(Address)

15 Filed ..... , 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from November 9, 1923 to November 12, 1923,

that I last saw him alive on November 12, 1923,

and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar, right Middle Lower Lobar

Myocarditis, acute

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. J. McCarthy M. D.

Nov 13, 1923 (Address) U.S. Marine Hosp. #1 Key Davis Ward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 11/14 1923

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80816

CERTIFICATE OF DEATH.

X183 D 80816

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. Camp Holabird, Maryland ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Reed, Private, Co"A" 1st MRBn., QMC.

(a) RESIDENCE. NO.... Camp Holabird, Maryland ST., WARD. Kegley. W Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ****

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	9	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Army

(c) Name of employer U.S.Government

9 BIRTHPLACE (city or town) (State or country) Kegley, W-Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Soldier's service record on file (Address)

15 Filed ..... 19.... Robert P. Harrison, Registrar

NOV 14 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to....., 19....., that I last saw h....alive on....., 19....., and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows: Died instantly, following GSW of head, entrance ¼"dia. tip of nose, exit ½" mid line 1½" above base occipital bone; accidentally shot with ball from .45 cal service revolver in hands of sentry at change of relief, at 4. P.M. Post No. 4, Camp Holabird, Md. Nov 13, 1923.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ***

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ****

(Signed) C. H. Witherell, M. D.

11/14 1923 (Address) Major, Med. Corps, USA.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kegley W. Va	11/14 1923
20 UNDERTAKER J. Thomson & Bro	ADDRESS 127 E Balto St

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 30817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30817

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Baby Lightstein

(a) RESIDENCE NO. 21 N. Wolfe St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 11-6-23

7 AGE: Years —— Months —— Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Johns Hopkins Hosp

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Rebecca

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Record (Address) John Hopkins Hosp

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Nov 8, 1923, that I last saw h[illegible] alive on Nov 8, 1923 and that death occurred, on the date stated above, at 1:15 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Induced Labor for Puerperal Eclampsia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan, M. D.

11/8, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: Nov 13 1923

20 UNDERTAKER: Commissioner Health. — ADDRESS

per Wm E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

359

[illegible] Robert P. Harrison, [illegible] 1 A 1023 [illegible] Burial Permit Clerk.

0802

Cor.—1-12-23—M&T—100 Bks.

D 80818

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 80818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Hanover St. ST., 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emerich Zlinszky.

(a) RESIDENCE No 1829 Hanover St. ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER DO not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Peter J. Welsh

(Address) 1829 Hanover St

15 Filed ....., 192 .....

Registrar

(Over) THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8; 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and kidneys.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.

(Coroner.)

Nov. 10, 192 3 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER .....

ADDRESS .....

Robert E. Harrison, Commissioner Health,

per ..... NOV 14 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8 56

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80819 D 80819

CERTIFICATE OF DEATH.

× 101-001 ✓

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 W. Hughes ST. 22 WARD

2-FULL NAME Benjamin Massey

(a) RESIDENCE NO. 9 W. Hughes ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years 39 Months ? Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Benj. Massey (Address) 9 W. Hughes St

15 Filed . . . . . 19 . . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1923

17 I HEREBY CERTIFY, That I attended deceased from 11/1/1923, to 11/11/1923.

that I last saw h alive on 11/10/1923

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos. 4 ds.

Influenza?

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Gunderson, M. D.

19 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS 3

N. 34'

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80820

CERTIFICATE OF DEATH.

D 80820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. P. Vragel

(a) RESIDENCE NO. 1026 Walnut St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith 206

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ? 11-13-23

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 23, 19 23, to November 13, 19 23, that I last saw h[illegible] alive on November 12, 19 23, and that death occurred, on the date stated above, at 12:35 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Residual Left Hemiplegia (Hemorrhage)

(duration) 1½ yrs. (history) mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude E. Heuisler, M. D.

19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Nov 16 23 19
20 UNDERTAKER	ADDRESS
Harry A. Witzke	1531 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 14 1923

Robert P. Harrison,

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80821

CERTIFICATE OF DEATH.

160

D 80821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Lauretta Ave ST., 20 WARD)

2-FULL NAME Emerson Townshend

(a) RESIDENCE NO. 2407 Lauretta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Townshend

11 BIRTHPLACE OF FATHER (city or town) Swissville (State or country) Penna

12 MAIDEN NAME OF MOTHER Bertha Wathen

13 BIRTHPLACE OF MOTHER (city or town) Swissville (State or country) Penna

14 Informant John Townshend (Address) 2407 Lauretta Ave.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th, 1923, to Nov 14, 1923, that I last saw him alive on Nov 13, 1923 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos 1 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm [illegible], M. D.

Nov 15, 1923 (Address) Eight E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov 15 1923

20 UNDERTAKER Wm Cook — ADDRESS 5022 York

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 14 1923

Agnes P. Harrison,

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80822 ✓ D 80822

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 westwood ave ST. 15 WARD)

2-FULL NAME Josephine Seris

(a) RESIDENCE NO. 3029 Westwood av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 ~~Single, Married~~, Widowed, ~~or Divorced. (Write the word)~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5 1864

7 AGE Years 79 Months ~~6~~ Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cefalu Italy

PARENTS

10 NAME OF FATHER Dominic Seris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Seris

(Address) 3029 Westwood av

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1923

17 I ~~HEREBY~~ CERTIFY, That I attended deceased from Oct 5 1923 to Nov. 13 1923.

that I last saw h alive on Nov 12 1923

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Hypertension.

General Arteriosclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial In-sufficiency (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. D'Amico, M. D.

, 19 (Address) 1604 Linden av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov 15 1923

20 UNDERTAKER H M Poulton — ADDRESS 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

NOV 14 1923 Robert P. Harrison, Deputy Health Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80823

CERTIFICATE OF DEATH.

129 D 80823

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 455 Illchester ave. 17 WARD)

2-FULL NAME Isabella A. Wiest

(a) RESIDENCE No. 455 Illchester ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Wiest

6 DATE OF BIRTH (month, day, and year): Mch. 2-1854

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home (37)

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: Wm. H. Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City

12 MAIDEN NAME OF MOTHER: Annie E. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Henry Wiest
(Address): 455 Illchester ave.

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922 to Nov 14, 1923.

That I last saw h alive on Nov 14, 1923

and that death occurred, on the date stated above, at 2-55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Disease
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Edema Lungs
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis

(Signed) Francis J. McCarthy, M. D.

....., 19 (Address) 416 E 20th ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. DATE OF BURIAL: Nov. 16 1923

20 UNDERTAKER: Wm. C. Black ADDRESS: 922 N. Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80824

CERTIFICATE OF DEATH.

101 D 80824

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4658 York Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sarah Boyd Burch

(a) Residence No. 4658 York Road St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur A. Burch

6-DATE OF BIRTH (month, day and year) March 1860

7-AGE. 63 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, George Boyd

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Jennie Mackey

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Mrs. Helen Ottaviano

(Address) 4658 York Road

15-

Filed..... 19..... Registrar.

NOV 15 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5th, 1923, to Nov. 13th, 1923.

that I last saw her alive on Nov. 12th, 1923.

and that death occurred, on the date stated above, at 12.45 A

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms.

(Signed) Theodosia D. Otten, M. D.

11-13-1923 (Address) 2827 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Olivet Cem	Nov 15 1923
20-UNDERTAKER. Joseph B. Cook	ADDRESS. 1003 N. Bolton St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Shilling

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80825

CERTIFICATE OF DEATH.

74-001

74 D 80825

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3912 Park Heights Ave ST., 15 WARD)

2-FULL NAME Isabelle Shilling

(a) RESIDENCE NO. 3912 Park Heights Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? 64 yrs. 2 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jas B Shilling

6 DATE OF BIRTH (month, day, and year) Sept. 5-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Alexander C. Gallagher

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabelle Foreman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Wm L. Gallagher
(Address) 4212 Eastern Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923, to Nov. 15 1923, that I last saw her alive on Nov 14 1923, and that death occurred, on the date stated above, at 5-10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
second attack

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) James B Eschbach, M. D.

Nov 15 1923 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sandy Mount Cem. Carroll Co Md	Nov 16 1923
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	W. Northern

ROBERT R. KRAUTER
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80826

CERTIFICATE OF DEATH.

X 185 D 80826

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE, (No.) Mercy Hospital ST., 4 WARD)

2-FULL NAME Lloyd B. Gilbert

(a) RESIDENCE NO. Elkridge Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	6	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Repairer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R R Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lorl Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Clautra Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ethel Gilbert
(Address) Elkridge

15 Filed ..... 192 ..... Registrar

NOV 15 1923 ROBERT R. KRAUTH
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to his death ~~from~~ (inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, fractured leg,

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ....., M. D.

11-13 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL Nov 16 1923

20 UNDERTAKER Harry W. Ebden

ADDRESS 1906 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80827 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80827

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1576 Druid Hill Ave. ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick G. Young

(a) RESIDENCE NO 1100 Druid Hill Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 26 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34		17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer) 125
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alfred Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Flora Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. F. G. Young
(Address) 1100 Druid Hill Ave.

15 Filed NOV 13 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Gastro enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 12, 1923 (Address) 220 Redwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt auburn cemetery	Nov 15 1923
20 UNDERTAKER John H. Taddiken	ADDRESS 42 N. Liberty St

DEATH should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 80828

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 80828

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Highland ST., No WARD)

2-FULL NAME George Washington Pry

(a) RESIDENCE No. 103 S Highland ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Blening (deceased)

6 DATE OF BIRTH (month, day, and year) Sept 6 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	83	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer-Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick, Co., Md. (State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Mollie M. Hoffman

(Address) 103 S. Highland

15 Filed ..... 19 ..... Registrar

NOV 5 1923 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 12, 1923 to November 14, 1923, that I last saw h.. alive on November 13, 1923, and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Allen C Burhans, M. D.

11-14, 1923 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marks Cem. Pikesville Md	11-16 1923
20 UNDERTAKER	ADDRESS
E & B Hasle	1158 W Mt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80829

CERTIFICATE OF DEATH.

7 A 80829

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1727 Clarkson ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Heline.

(a) RESIDENCE. NO. 1727 Clarkson ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Annie F.Heline.

6 DATE OF BIRTH (month, day, and year) Dec.13,1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69,	11,	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas & Electric Co.

9 BIRTHPLACE (city or town) (State or country) Norfolk,Va.

PARENTS

10 NAME OF FATHER Adam Heline.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles H. Heline.
(Address) 1727 Clarkson St..

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Nov 14, 1923,

that I last saw h alive on Nov 14, 1923,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. T. Campbell M. D.

Nov 15, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Nov. 17, 1923.

20 UNDERTAKER A Howard Evans ADDRESS 1428 S. CHARLES ST.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80830

CERTIFICATE OF DEATH.

Registered No. 101-D 80830

1-PLACE OF DEATH

City of BALTIMORE: (No. 1430 Decatur St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosalie A. Cornell

(a) Residence No. 1430 Decatur St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, white.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 18. 1921

7-AGE. 2 yrs. 1 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED.
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of Industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Lorain W. Cornell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Annie R. Hudson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Delaware

11- (Informant) Lorain W. Cornell
(Address) Balto Md

15-
Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1923 to Nov. 14 1923 that I last saw her alive on Nov 13 1923, and that death occurred, on the date stated above, at 6 am.

The CAUSE OF DEATH* was as follows:

Coma, Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Chas. F. Stevens M. D.

11/14, 1923 (Address) 2878 Hartford

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Nov. 16, 1923

20-UNDERTAKER. A. Howard Evans ADDRESS 1428 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT P. KRAUTER
NOV 15 1923
CLERK CIRCUIT COURT

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fern Rea Bodo & daughter & nurse ST.: 15 WARD) REGISTERED No. C 80831

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston R. Chilcoat

(Residence in Baltimore: No. 2228 Pennsylvania Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct. (Month) 6 (Day), 1899 (Year)

7-AGE, 24 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer): Yellow Cab Co.

9-BIRTHPLACE, (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER, Thomas M. Chilcoat

11-BIRTHPLACE OF FATHER (State or Country) Balto. Co. Md

12-MAIDEN NAME OF MOTHER Lyda E. Morris

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) Mrs. Lyda E. Chilcoat

(Address) 1715 N. Monroe St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Chronic valvular disease of heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Riddens

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

(Coroner.)

Nov. 16, 191[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fairburg (Balto. Co.)

DATE OF BURIAL, Nov. 17, 19[illegible]

20-UNDERTAKER Horace M. Burgee

ADDRESS 363 Falls Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80832

CERTIFICATE OF DEATH.

31 D 80832

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 201 W. Hoffman St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Bell

(Residence in Baltimore: No. 201 W. Hoffman St. St.; 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): single

6-DATE OF BIRTH: about (Month) (Day) 1899 (Year)

7-AGE: 24 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Housework. (b) General nature of Industry, business, or establishment In which employed (or employer): 070

9-BIRTHPLACE (State or Country): Md.

PARENTS.

10-NAME OF FATHER: John E. Bell

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Lillian Hinson

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bell

(Address) 455 Pierce St.

15-

Filed ..... 192.....

ROBERT R. KRAUTER

NOV 15 1923 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. (Month) 13, (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. S. Hennessy, M. D. (Coroner.)

Nov. 14, 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Nov. 16 1923

20-UNDERTAKER: Arnold D. Hensley ADDRESS 515 N. Bradford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80833 HEALTH DEPARTMENT—CITY OF BALTIMORE 80833

91-007

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home of Incurable ST., 12 WARD)

2-FULL NAME Annie B Hoffman

(a) RESIDENCE NO. Home of Incurable ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Hoffman

6 DATE OF BIRTH (month, day, and year) Nov 3 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John B. Chenoweth

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah B Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Bess C. Henderson

(Address) Hanover Pa

15 NOV 15 1923 ROBERT R. KRAUTER Registrar

Filed ..... 19 ... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Nov 13 '23, 19 ....., that I last saw her alive on Nov 12, 1923, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrilation

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No What test confirmed diagnosis? Physical Diagnosis

11 (Signed) P W B Mayo, M. D.

11/14, 1923 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Nov 15 1923

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 80834

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-001 D 80834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3732 Greenmount Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Jackson Bradford.

(a) RESIDENCE NO. 3732 Greenmount Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Stevenson

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary & Treas.

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer American Towing Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Nelson Bradford

11 BIRTHPLACE OF FATHER (city or town) ----- (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary A McAdams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Mary E Bradford (Address) 3732 Greenmount Ave

15 Filed NOV 15 1923, 19 ROBERT M. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923, to Nov 13, 1923, that I last saw h alive on Nov 12 1923, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Bruce M. D.

11/14 1923 Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Nov 15 1923

20 UNDERTAKER: H. W. Mears & Son — ADDRESS: 805 N Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80835

CERTIFICATE OF DEATH.

90 D 80835

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 107 E Church St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Malone

(a) Residence No. 107 E Church St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lilly Malone

6-DATE OF BIRTH (month, day and year): July 2 1861

7-AGE: 62 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Somerset Co Maryland

PARENTS.

10-NAME OF FATHER: Henry Malone

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Somset Co Maryland

12-MAIDEN NAME OF MOTHER: Sarah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Somset Co Maryland

14- (Informant): Mrs Lilly Malone

(Address) 107 E Church st

15- Filed, 192 Registrar.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 14 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1923 to Nov 14 1923

that I last saw h[illegible] alive on Nov 14 1923

and that death occurred, on the date stated above, at 8 55 a m.

The CAUSE OF DEATH* was as follows:

Mitral

Regurgitation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 16 1923 (Address) 831 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A A Ch'd

DATE OF BURIAL: Nov 16 1923

20-UNDERTAKER: John F Denny

ADDRESS: 715 Lig[illegible] St

NOV 15 1923

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80836

CERTIFICATE OF DEATH.

3/ D 80836

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 E Cross ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick P Freund

(a) RESIDENCE NO. 112 E Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1914

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
8	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip J Freund

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma V Kash

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Philip J Freund (Address) 113 E Cross St

15 Filed NOV 16 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Nov 14, 1923, that I last saw him alive on Nov 12, 1923, and that death occurred, on the date stated above, at 6.38 A m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Spine (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Nov. 1923 (Address) 129 Caroll St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Nov 16 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Blks.

D 80837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 80837

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary ST., 27 WARD)

2-FULL NAME William H. Dif

(a) RESIDENCE NO. 203 Club Road Roland Park ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Dif

6 DATE OF BIRTH (month, day, and year): July 19, 1858

7 AGE — Years: 65 yrs. Months: 3 Days: 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: J. Franklin Dif

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont

12 MAIDEN NAME OF MOTHER: Rebeca

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Mary E. Dif

(Address) Woodbrook Apartments

15 Filed ....., 19..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18th, 1923, to Nov 14th, 1923,

that I last saw him alive on Nov 14th, 1923,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cancerous myelitis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 9-19-23 10-9-23

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) L. M. Pahrogt, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Nov 17 1923

UNDERTAKER: John B. Spence — ADDRESS: 1325 N Caroline St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80838

D 80838

CERTIFICATE OF DEATH.

Time of funeral extended to Friday 2 P.M. Nov 16/23. Interment Greenmount Cem. [illegible]

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 20 Poultney St. ST., 23 WARD)

2-FULL NAME Catherine Dieringer.

(a) RESIDENCE NO. 20 Poultney St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married

5a If married, widowed or divorced
(of) WIFE of Henry Dieringer.

6 DATE OF BIRTH (month, day, and year) January 26, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	38	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Roehmer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Noll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Henry Dieringer (husband).
(Address) 20 Poultney St.

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Clerk. Burial Permit Clerk. NOV 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 10, 1923. to November 14th 23.

that I last saw her alive on November 14, 19 23.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

Toxaemia.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Wm. C. Reinhardt, M. D.

11/14 28 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Nov 16th 1923

20 UNDERTAKER E. Schlosman & Son ADDRESS 1024 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80839

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 3 N. Hare St ST., 6 WARD)

2-FULL NAME Alexander McFaul

(a) RESIDENCE NO 3 N. Hare St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret McFaul

6 DATE OF BIRTH (month, day, and year) Feb 17/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel McFaul

11 BIRTHPLACE OF FATHER (city or town)
(State or country) County Entrem Ireland

12 MAIDEN NAME OF MOTHER Rose Wilkerson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Glascow Scotland

14 Informant Margaret McFaul
(Address) 3 N. Hare St.

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Fractured skull-Fell down cellar steps.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Wallen, M. D.
(Coroner.)

Nov 14/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 11/16/ 1923

20 UNDERTAKER J. A. Moran

ADDRESS 300 E. Baltch.

Burial Permit Issued

Before signing be careful to see that all items are answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80840

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 D 80840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Maurer

(a) RESIDENCE NO. 6 S. Haven ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	married.

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Philip Maurer

6 DATE OF BIRTH (month, day, and year) Jan 7-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Frank R. P. Bohagen

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bautsch

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Philip Maurer
(Address) 6 S. Haven St.

15 Filed NOV 15 1923 ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1923.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1923, to Nov. 13, 1923,

that I last saw h~~e~~ alive on Nov. 13, 1923,

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) pre partum Eclampsia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P+S+S. —

(Signed) Harold C. Bellsmyer M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	11/17th 1923
20 UNDERTAKER J. A. Moran	ADDRESS 300 E. Baltimore.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 ✓ D 80841

Registered No.

1-PLACE OF DEATH

City of BALTIMORE. (No. 1618 E Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Geo. Boehm.

(a) Residence No. 1618 E Lombard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of E Boehm

6-DATE OF BIRTH (month, day and year) Oct. 11 1841

7-AGE, 82 yrs. 1 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) 806

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Boehm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Not Known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Mrs. J. Rogers

(Address) 1618 E Lombard

15- Filed NOV 15 1923 Registrar. ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 14 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 25th, 1923, to Nov 14th, 1923, that I last saw h alive on, 19, and that death occurred, on the date stated above, at 6 P M

The CAUSE OF DEATH* was as follows:

Coma

(Duration) yrs. mos. 2 ds

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L Wasman, M. D.

11-15, 1923 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL, Nov 17, 1923

20-UNDERTAKER, E Tiernan ADDRESS 30 S Broadway

I. B. WHITE CO., PRINTING AND RULING, BALTIMORE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80842 D 80842

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 N Calhoun ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M Frost

(a) RESIDENCE NO. 812 N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Amon Richards

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Margaret Bush

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14

Informant Howard R Frost

(Address) 812 N Calhoun St

15

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1923, to Nov. 14, 1923,

that I last saw her alive on Nov. 14, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. C. McCarthy M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 5 19
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Robert E. Garrison,

NOV 5 1923

Registrar

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80843

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2220 E. Lanvard St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Baumohl

(a) Residence No. 2220 E Lanhard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Baumohl

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Louis Kesler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Jack Louis

(Address) 1439 E Balto St

13-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-15-23

17- I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923 to Nov 15, 1923

that I last saw h.r alive on Nov 14, 1923,

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) A.C. Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Non

(Signed) Hubert Thomas M. D.

Nov 15, 1923 (Address) 1816 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Mt. Carmel

DATE OF BURIAL. Nov. 15 23

20-UNDERTAKER. Jas Lewis, 1439 E Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127 D 80844

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... CUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for the Women of Md. ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jane Langrill

(a) RESIDENCE NO. 1613 Friendsbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married

5a If married, widowed, or divorced (or) WIFE of Joseph Langrill

6 DATE OF BIRTH (month, day, and year) 1866 (Not Known)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) County Wicklow (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew Langrill

11 BIRTHPLACE OF FATHER (city or town) Coppaugh (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) Dublin (State or country) Ireland

14 Informant Joseph Langrill (Address) 1613 Friendsbury St., City.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1923, to Nov. 14, 1923,

that I last saw h.r alive on Nov. 14, 1923,

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov. 14, 1923

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) G. T. Goff, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 17 1923

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmt

NOV 15 1923 Robert P. Harrison, Burial Permit Clerk.

Cor.—1-12-23—M&T—100 Bks.

D 80845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-09 80845

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 10 WARD)

2-FULL NAME Caroline Voldicka

(a) RESIDENCE NO Little Sisters of Poor Valley & Pratt

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence
(Address) Little Sisters of Poor

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-Intercranial Hem.
Struck by street car.
(Inquest to be held Nov. 15/23)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S K Collins, M. D.
(Coroner.)
Nov. 15 23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov. 16. 1923

20 UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Gaussert Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80846

CERTIFICATE OF DEATH.

161-001 D 80846

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 S 13th St. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Compana

(a) RESIDENCE NO. 635 S 13 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 17 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Ralph Compani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francis Belluchi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Ralph Compani (Address) 635 S 13th

15 Filed . . . . . 19 . . . . . Registrar

NOV 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from 11. 14. 1923 to 11. 15. 1923

that I last saw him alive on 11. 14. 1923

and that death occurred, on the date stated above, at 3 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Norris M. D.

11/15/23. (Address) 107 E. west st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem DATE OF BURIAL Nov 16 1923

20 UNDERTAKER John Welsh ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80847 D 80847

CERTIFICATE OF DEATH.

162 23

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Pearson

(a) RESIDENCE NO. 1112 Druid ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER J Harry

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) Robert F. Harrison

15 Filed NOV 15 1923, 19 Registrar

Burial Permit Clerk

0867

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923, to Nov. 12, 1923,

that I last saw him alive on Nov. 12, 1923,

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Spontaneous hemorrhage of the newborn

(duration) yrs. mos 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? ~~Sign & symptoms~~

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL NOV 14 1923

20 UNDERTAKER [redacted] ADDRESS

Commissioner of Health,
Per. Wm. H. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80848

CERTIFICATE OF DEATH.

D 80848

161-006

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 725 N. Mount ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Burney

(a) RESIDENCE. NO. 725 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward Burney

11 BIRTHPLACE OF FATHER (city or town) Pitt County
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary J. Blount

13 BIRTHPLACE OF MOTHER (city or town) Pitt County
(State or country) N. C.

14 Informant Edward Burney
(Address) 725 N. Mount St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 19 23, to Nov. 14, 19 23, that I last saw h.. alive on Nov. 14, 19 23, and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Dystocia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas Edw Bell, M. D.

, 19 (Address) 1122 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

NOV 15 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. 345

D 80849 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pimlico Race Track Registered No. C.....

City of BALTIMORE: (No. Pimlico St., 24 Ward)

—(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Douglas Somerford

(Residence in Baltimore: No. Pimlico Race track St.; yrs....., mos....., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: C.

5-Single, Married, Widowed, or Divorced: Single (Write the word.)

6-DATE OF BIRTH: Unknown ....., 1..... (Month) (Day) (Year)

7-AGE: Over 30 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Jockey
(b) General nature of industry, business, or establishment in which employed (or employer): Stable work

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: "

11-BIRTHPLACE OF FATHER, (State or Country): "

12-MAIDEN NAME OF MOTHER: "

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JOHNS HOPKINS HOSPITAL

Filed ..... 192 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound through head (Homicidal)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D. (Coroner.)

Nov 13 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ... 19..

20-UNDERTAKER, ADDRESS

Buried Forest Glen Nov 15 1923

0869 THE MORGUE.

Spec.—1-10-21—M&T—1500 Blks.

D 80850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 ✓ D 80850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 S. Durham ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sebbett

(a) RESIDENCE NO. 108 S Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 31, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Wesley Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant

(Address)

15 Filed ..., 19 ... Registrar

Buried ... Sexton.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to ~~Oct~~ Nov 9, 1923 that I last saw him alive on Nov 9, 1923 and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Duncan M. D.

11/10, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS NOV 14 1923

Per. Wm. E. WOODALL.

NOV 15 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80851 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-001 D 80851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 S. First St. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara A Leitner

(a) RESIDENCE NO. 919 S. First St. ST., 76 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Leitner

6 DATE OF BIRTH (month, day, and year) Feb. 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John Stensler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Katherine Hauft.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) Daniel Leitner 919 S. First St.

15 Filed NOV 15 1923, 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to Nov. 12, 1923, that I last saw her alive on Nov. 12, 1923 and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 10 Hours.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. J. Lechleitner M. D.

Nov 15, 1923 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cem. Belair Rd.	Nov 16 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80852 ✓ D 80852

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jaworski

(a) RESIDENCE No. 3020 Hudson st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator. Sewing Machine

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Arvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Schnittel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records (Address): M.T.H.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 19 23, to Nov. 14, 19 23,

that I last saw her alive on Nov. 14, 19 23,

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray and sputum

(Signed) L. A. Lally, M. D.

11-14-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dand Hill Cem

DATE OF BURIAL: 11/17 19 23

20 UNDERTAKER: Geyer & Daly Fulton Fayette

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert P. Harrison, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80853

D 80853

CERTIFICATE OF DEATH.

REGISTERED NO. 11

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 120 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mc Dade.

(a) RESIDENCE NO. 1809 Penrose Ave ST., WARD Brooklyn N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 3 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
9 yrs.		4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: N. H.

9 BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS

10 NAME OF FATHER: Michael Mc Dade

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hattie Schwabenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. M. Mc Dade. (Address) 1809 Penrose Ave.

15 Filed , 19 Registrar

Robert P. Harrison
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/13 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-11, 1923, to 11-13, 1923, that I last saw h[illegible] alive on 11-13, 1923, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/11/23

Was there an autopsy? No

What test confirmed diagnosis? Phys. Findings

(Signed) H U Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/14/23

20 UNDERTAKER: Geo A Tully Fulton Augusta — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CV 151023

Spec.—1-10-21—M&T—1500 Blks.

D 80854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80854

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jamie Dyson

(a) RESIDENCE NO. 437 W. Monument St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from November 10, 1923, to November 13, 1923,

that I last saw him alive on November 12, 1923,

and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis

Aneurysm of Arch of Aorta

(duration) yrs. 6 mos ds.

CONTRIBUTORY .....

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude T. Hines M. D.

19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Nov 16 1923

20 UNDERTAKER Brown & Sheeland

ADDRESS 1400 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

2-FULL NAME Columbus Z. Boetler (Botelen)

(a) RESIDENCE NO 515 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced (write the word)~~
Male	White	Widower

5a If married, widowed, or divorced
~~(a) WIFE of~~ HUSBAND of Cassandra A. Boetler

6 DATE OF BIRTH (month, day, and year) July 9/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Store-keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George M. Boetler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen A. ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Ellen C. Badders
(Address) 515 E. Preston St.

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Struck by Automobile
Fractured Skull (Posterior Occiput.)
(Inquest to held Nov. 15/23)
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ~~yrs.~~ ..... mos. ..... ds.

(Signed) J. S. O'Donnell, M. D.
(Coroner.)

Nov 15/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov 17 192 3

20 UNDERTAKER Wm Cook & Son E. Monument Sq — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80856

CERTIFICATE OF DEATH.

74001 ✓

D 80856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Dora Miller

(a) RESIDENCE NO. 29 W. Preston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frederick R. Miller

6 DATE OF BIRTH (month, day, and year) Feb 27 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Kinding

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Bullet

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Hospital Records.
(Address)

15 Filed ....., 19 .....
Registrar

NOV 5 1923

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13/23. 19

17

I HEREBY CERTIFY, That I attended deceased from 11/13/23, 19, to 11/13/23, 19,

that I last saw h[illegible] alive on 11/13/23. 19,

and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

three (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dolley M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL Nov 16 1923

20 UNDERTAKER Wm. Cook

ADDRESS 501 E Monument

Spec.—1-10-21 M&T 1500 Bks.

D 80857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 80857

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3909 Dalrymple ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Parks.

(a) RESIDENCE NO. 3909 Dalrymple ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Parks.

6 DATE OF BIRTH (month, day, and year) Jan 10 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John A. Parks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Longley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John E. Parks. 3003 Belleville ave

15 Filed NOV 16 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Nov 15, 1923, that I last saw h alive on Nov 15, 1923, and that death occurred, on the date stated above, at 12 00 M. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R E R Campbell M. D.

Nov 16, 1923 (Address) 1647 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem.

DATE OF BURIAL 11/17 1923

20 UNDERTAKER J. Fen McCully

ADDRESS 1306 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80858

CERTIFICATE OF DEATH.

90

D 80858

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 908 Pine ST. (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Grank

(a) RESIDENCE NO. 908 Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Grank

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 60, Months —, Days —, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emma Grank (Address) 908 Pine

15 Filed , 19 NOV 16 19 ROBERT R. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Nov 14, 1923, that I last saw him alive on Nov 13, 1923, and that death occurred, on the date stated above, at 1230 A m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William E Burton, M. D.

, 19 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11-16-1923

20 UNDERTAKER: Daniel Easton

ADDRESS: 916 Penn.

Filed Record Clerk

Spec.—1-10-21—M&T—1500 Bks.

80859 HEALTH DEPARTMENT—CITY OF BALTIMORE 80859

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 609 W Mulberry ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Arrigo

(a) RESIDENCE NO. 609 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 8 23

7 AGE: Years — Months 10 — Days 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Vincent Arrigo

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) DC

12 MAIDEN NAME OF MOTHER Rose Cusmilio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Arrigo (Address) 609 W Mulberry.

15 Filed ..., 19 ... ROBERT R. KRAUTER, Registrar

NOV 16 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1923, to Nov 15, 1923, that I last saw h[illegible] alive on Nov 15th, 1923 and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Laryngeal Diphtheria

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Canastay

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Gustav Wolcman, M. D.

, 19 (Address) 656 W Franklin.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent — DATE OF BURIAL 11-16-1923

20 UNDERTAKER David Easton — ADDRESS 916 Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See affadivit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80860 100-001 D 80860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rider

(a) RESIDENCE NO. 755 W. Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Ab.

6 DATE OF BIRTH (month, day, and year) ~~1858~~ 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~74~~ 73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Walter Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget O'Connors

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Municipal Hospital Records.

15 Filed . . . . 19 . . . . Registrar

NOV 16 1923 ROBERT R. KRAUTER Registrar Public Health Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 5 , 19 23, to November 14 19 23, that I last saw h.. alive on November 14 , 19 23, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

Chronic Infectious Arthritis (Hypostatic)

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (Terminal) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Charles J. Drake, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 19 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hay[illegible] Ave

Personally appeared before me this 16th day
Of November 1923. Mr John T. Randall
Son in Law. of Mrs Mary T Rider who made
affadavit that the age given on Death Certificate
#D.80860 is incorrect the same should be
read. 73 years

Seal John T Randall (Son in Law

Seal. George H Gresse
Notary Public

Spec.—1-10-21—M&T—1500 Bks.

B 80861

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80861

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1122 N. Mount ST. 15 WARD)

2-FULL NAME Charles Patten

(a) RESIDENCE NO. 2612 Stevens Court ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida Patten

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Balto. Copper Works

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Wife Freida Patten

(Address) 2612 Stevens Court.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1923 to Nov. 15, 1923, that I last saw him alive on Nov. 15, 1923 and that death occurred, on the date stated above, at 1.10 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ~~yrs.~~ ~~mos.~~ 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ~~yrs.~~ ~~mos.~~ 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) A. A. Spoerman, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov 17 1923

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80862

CERTIFICATE OF DEATH.

124 D 80862

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 27 WARD)

2-FULL NAME Rebecca Berger

(a) RESIDENCE NO. 224 W. Woodland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: ~~Russian~~ White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Berger

6 DATE OF BIRTH (month, day, and year): Aug. 15, 1883

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Nathan Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Nultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 E. Baltimore St.

15 Filed AUG 16 1923, 19 ... Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1923, to Nov. 15, 1923, that I last saw her alive on Nov. 15, 1923 and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute cholecystitis, with rupture of gall bladder & general peritonitis

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Nov. 13, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) P.B. Price, M. D.

Nov. 15, 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 8/16 1923

20 UNDERTAKER: Jack Lewis 1439 E. Baltimore St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80863

CERTIFICATE OF DEATH.

114 D 80863

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 738 Cumberland St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Aaronson

(a) Residence No. 738 Cumberland St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 9/1917

7-AGE. 6 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Richmond Va

PARENTS.

10-NAME OF FATHER Isaac Aaronson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lena Michelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore St

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/15/23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1923 to Nov. 15, 1923

that I last saw h.. alive on Nov. 15, 1923

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. 8 mos. dys.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis & Examination

(Signed) Isaac M. Fruchs M. D.

. 19 (Address) 7352 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rehrein Cosedale

DATE OF BURIAL. 11/16, 1923

20-UNDERTAKER. Jack Lewis 1439 E Baltimore St

ADDRESS

N. B.—WHITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—J-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80864 — CERTIFICATE OF DEATH. — X 100-001 D 80864

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Sharp ST. 23 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Wolf

(a) RESIDENCE NO. 902 S. Sharp ST., ... WARD ... Calvert Co Md
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June, 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Wolf.

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Gross.

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland.

14 Informant Elsie Gross
(Address) 902 S Sharp St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov, 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov, 9, 1923. to Nov, 14 1923.

that I last saw h alive on Nov, 14 1923.

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia
(Primary)

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Dan Franklin M. D.

11/17 1923 (Address) 122 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	11/16/23

20 UNDERTAKER Sarah E. Brown & Sons — ADDRESS 1082 Montgomery

NOV 16 1923 ROBERT R. KRAMER
Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80865

CERTIFICATE OF DEATH.

24-091 D 80865

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 925 Bolair Rd ST.; 26 (WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw D Kunkle

(Residence in Baltimore: No. 925 Bolair Rd St.: 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, June 20, 184[illegible] (Month) (Day) (Year)

7-AGE, 76 yrs. 4 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Kunkle

(Address) Gardenville

15-

Filed NOV 16 1923, 191.....

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15 (Month) (Day), 1923 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 31 1923, to Nov 15 1923, that I saw h[illegible] alive on Nov 14 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw D Corse M. D.

Nov 15 1923 (Address) Gardenville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Nov 17 1923
20-UNDERTAKER	ADDRESS
Mr & Mrs. John N. Teufel & Son	801 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80866

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 ✓

D 80866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1260 Washington Boulevard (STREET) 21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Fritz

(a) RESIDENCE No. 1260 Washington Blvd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Elizabeth Fritz

6 DATE OF BIRTH (month, day and year): Sept. 13-1880

7 AGE — Years: 43 — Months: 2 — Days: 2. — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O R R

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Friedrich Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Clara Reitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth A. Fritz

(Address): 1260 Washington Boulevard

15 Filed ... 19 ... Registrar

NOV 16 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15. 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 5 , 1923 , to Nov 15 , 1923 ,

that I last saw him alive on Nov 15 , 1923 ,

and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Grip

(duration) ... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ray Ford Dunn, M. D.

11/15, 1923 (Address) 6 W Mount Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Mr. & Mrs. John H. Teufel & Son — ADDRESS: 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80867

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 713 Mushes (Mosher) ST., 14 WARD) 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Diggs

(a) RESIDENCE NO. 713 Mushes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18-07

7 AGE: Years 16 Months 1 Days 26

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER J. R. L. Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alberta Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Alberta Diggs (Address) 713 Mushes

15 Filed NOV 16 1923 ROBERT R. KRAUTER, Registrar

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 — 1923 to Nov-14 1923.

that I last saw h/r alive on Nov-14 1923,

and that death occurred, on the date stated above, at 7:40 p m.

The CAUSE OF DEATH was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Gerlman M. D.

11-15 1923 (Address) 39 W. Cuelock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov 16 1923

20 UNDERTAKER: Jas. W. Grace & Son

ADDRESS: 1400 Mosher

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80868

101-001 D 80868

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1821 E. Biddle ST., 8 WARD)

2-FULL NAME Louis. P. Kline

(a) RESIDENCE NO. 1821 E Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Febuary 13 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer): Street paver

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr Jacob P. Kline.

(Address): 1821 E. Biddle

15 Filed ..... , 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1923. to Nov 15, 1923.

that I last saw h alive on Nov 14, 1923

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. F. Hamer, M. D.

Nov 15 1923 (Address) 1301 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery DATE OF BURIAL: Nov. 17 1923

20 UNDERTAKER: Henry Storck Son ADDRESS: 1201 E Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D 80869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80869

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 N. Eutaw ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Madden

(a) RESIDENCE NO. 1014 N. Eutaw ST., WARD

(Usual place of abode) also

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., If of foreign birth? 72 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Patrick Madden

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE: Over 77 Yrs. — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Thomas Barry.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Fannie McColgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Miss. Mamie Madden

(Address) 1014 N. Eutaw

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18th, 1923, to November 15th 1923, that I last saw h[illegible] alive on November 15th, 1923, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis.

(Duration) about 4 years mos. ds.

CONTRIBUTORY (Secondary) Colitis - Exhaustion.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard E. Snader, M. D.

11/16, 1923 (Address) 530 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov. 19 1923

20 UNDERTAKER: Henry Stock Son — ADDRESS: 1301 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 16 1923 ROBERT H. KRAUTER, Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 80870

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Wolfe St. ST.: 6 WARD)

2-FULL NAME Frederick C. Eikenberg

(a) RESIDENCE. NO. 418 N. Wolfe St. ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Eikenberg.

6 DATE OF BIRTH (month, day, and year) July 30th 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman in Street Cleaning Dept.

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Julius Eikenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Eikenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Eikenberg. (Address) 418 N. Wolfe St.

15 Filed NOV 15 1923 ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to November 14, 1923, that I last saw h~~im~~ alive on November 14, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Glioma (Brain Tumor)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) # yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of January 1923

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Frank J. Ayd, M. D.

Nov 15, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 17 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S Wolfe St

N. B.—WRITE PLAINLY, WITH INDIA INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Malignant

Spec.—1-10-21—M&T—1500 Bks.

D 80871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80871

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital, John ST., 27th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sellards

(a) RESIDENCE NO. Pennsylvania Ave — Mt Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 11 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 0 hrs. or 20 min.
	0	0	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Sellards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Hannah H. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant Mrs. Sellards
(Address)

15 Filed ..... 19 .....
ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1923 10 30 A.M. to 11 P.M. Nov. 11, 1923,

that I last saw him alive on Nov. 11, 1923,

and that death occurred, on the date stated above, at 11 00 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ND Date of —

Was there an autopsy? ND

What test confirmed diagnosis? Physical exam

(Signed) John G. Murray M. D.

Nov 11, 1923 (Address) Womens Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Foundation W.H.H.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80872

D 80872

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 129 E Hughes (St.) 22 (Ward)

2-FULL NAME Mary A Fitzpatrick

(a) RESIDENCE. No. 129 E Hughes St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J Fitzpatrick

6 DATE OF BIRTH (month, day, and year) Apr 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nicholas Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs J. Fitzpatrick

(Address) 129 E Hughes St

15 Filed ..., 19... Registrar

NOV 16 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to Nov 13, 1923, that I last saw her alive on Nov 13, 1923, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys & Lab.

(Signed) Wm Lebherz, M. D.

11/14 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Nov. 17 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	7039 Fonrest St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80873 — 162 — D 80873

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 418 Tuxedo ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shipley

(a) RESIDENCE. NO. 418 Tuxedo ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 0b0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harold B. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co Md

14 Informant Emma T Baker

(Address) 418 Tuxedo St. JOHNS HOPKINS HOSPITAL

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1923, to Nov 14, 1923

that I last saw h.. alive on Nov 14, 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Cyanosis.

(Morbus Coeruleus

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Wm Ntl M. D.

11/15. 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Per. Wm. E. WOODALL

Commissioner Health.

NOV 16 1923

NOV 16 1923 Burial Permit Clerk

0872

34

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 80874

REGISTERED NO. D 80874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Launstein

(a) RESIDENCE NO. May View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ? 11-15 1923

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 11, 19 23, to November 14, 19 23,

that I last saw h alive on November 14, 19 23,

and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Senile Debilitation

Chronic Infectious Arthritis (Hypertrophic)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Aut.

(Signed) Clinde A Heise, M. D.

(Address) Municipal Hospital. 11-15 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL NOV 16 1923 19

20 UNDERTAKER Commissioner Health.

ADDRESS

For Wm F. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

44

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80875

CERTIFICATE OF DEATH.

31 D 80875

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Lee

(a) RESIDENCE NO. 606 Morrow's Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.. min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 14, 19 23, to November 15, 19 23,

that I last saw h alive on November 14, 19 23,

and that death occurred, on the date stated above, at 1:10 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. (1 day) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Drane M. D.

11-15, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 11/16 1923

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

NOV 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 80876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 80876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2609 Roslyn ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Perkins Munder

(a) RESIDENCE NO. 2609 Roslyn ave ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? 70 yrs. 6 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Matilda Munder

6 DATE OF BIRTH (month, day, and year): May 7-1853

7 AGE — Years: 70 — Months: 6 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Md. Baltimore

PARENTS

10 NAME OF FATHER: Louis Munder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Balto. Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Mrs Matilda Munder (wife)
(Address) 2609 Roslyn

15 Filed NOV 16 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1923, to Nov 14, 1923, that I last saw him alive on Nov. 13, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage — paralysis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis — High Blood pressure

Chronic interstitial Nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W.S. Niblett, M. D.

11/14/23 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 16 1923.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80877 ✓ D 80877

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Baker ST. 15 WARD)

2-FULL NAME Hazel Dwinelle Moore,

(a) RESIDENCE NO. 1829 Baker ST., ... WARD 15

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 22, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): -----

(c) Name of employer: -----

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Harry D Moore

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER: Ida Lee Melson

13 BIRTHPLACE OF MOTHER (city or town) ----- (State or country) Virginia

14 Informant: Harry D Moore

(Address) 1829 Baker St.

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

NOV 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 19 23

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 17 19 23
20 UNDERTAKER	ADDRESS
H. W. Mears & Son	805 N Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Early return of this certificate is necessary. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80878

CERTIFICATE OF DEATH.

90 D 80878

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3404 Alto Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Alberta Sutton

(Residence in Baltimore: No. 3404 Alto Ave St.: 65 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 16, 1858
(Month) (Day) (Year)

7-AGE, 65 yrs. — mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Sutton

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Chaudiam

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida E. Sutton

(Address) 3404 Alto Ave

15-

Filed....., 191.....

NOV 16 1923 ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1923, to Nov 15 1923.

that I saw h[illegible] alive on Nov 15 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration), yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.

(Signed) [illegible] M. D.

Nov 16, 1923 (Address) 1014 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge

DATE OF BURIAL, Nov. 17, 1923

20-UNDERTAKER Geo W Settle

ADDRESS 2700 Edmondson

Knach

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80879 D 80879

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909, 12th St.: N. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Knach

(a) RESIDENCE. No. 909, 12th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Knach

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lizzie Fox

(Address) 909 N 12th St

15 Filed ..... 19 ..... Registrar

NOV 16 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Nov 15, 1923, that I last saw her alive on Nov 13, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Contusion of Knee

(duration) — yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettitacue, M. D.

, 19 (Address) 617 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem.

DATE OF BURIAL: 11/17/23

20 UNDERTAKER: Wendell Dippel Son

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80880

D 80880

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4139 Park Heights St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Corinne Lewis Price

(a) RESIDENCE NO. 4139 Park Heights St., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 31 yrs. 2 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry B. Price

6 DATE OF BIRTH (month, day, and year): Sept-10-1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
31	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 37

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Crumpton Maryland

PARENTS

10 NAME OF FATHER: Jas. Woodall Ryland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crumpton Maryland

12 MAIDEN NAME OF MOTHER: Lillie L. Godwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Crumpton Maryland

14 Informant: Mr Harry B. Price

(Address) 4139 Park Heights Av.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1923, to Nov. 14, 1923, that I last saw her alive on Nov. 13, 1923, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr. Harry Strag, M. D.

Nov. 19 23 (Address) 729 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crumpton Queen Anne Co. Md.

DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: [illegible] & BOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: [illegible]

Robert F. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC
mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exac
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80881 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80881

109-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4135 Roland Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Clay Timanus

(a) RESIDENCE No. 4135 Roland Ave ST., 13 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? 60 yrs. 2 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Lowry Timanus

6 DATE OF BIRTH (month, day, and year) Sept-2-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Member of the

(b) General nature of industry, business, or establishment in which employed (or employer) Racing Commission

(c) Name of employer State of Maryland

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Timanus

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jannie Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Grace L. Timanus (wife)

(Address) 4135 Rolandave

15 Filed ....., 19 ..... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from June 13, 1923, to Nov. 15, 1923, that I last saw him alive on Nov. 15, 1923 and that death occurred, on the date stated above, at 245A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from vessels in brain

Immediate Cause

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Vincents Angina

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Standish McCleary M. D.

, 19 (Address) 1609 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Nov 19 1923

20 UNDERTAKER STEUART & MOWEN COMPANY

ADDRESS 103 W. NORTH AVE

NOV 6 1923

Robert J. Barrison, Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80882

CERTIFICATE OF DEATH.

D 80882

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Exeter ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Green

(a) RESIDENCE. NO. 517 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: McKeown

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years: 53 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 04

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country):

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Cath. Darrison (Address) 517 N. Exeter St.

15 Filed 11-18, 1923. Registrar: Robert F. Garrison, Commissioner of Health.

NOV 16 1923 Burial Clerk 0823

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1923, to Nov 14, 1923.

that I last saw him alive on Nov 14, 1923,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

(Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 16 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80883 — 001 — D 80883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Cooks Lane (St.) near Edmondson Ave (Ward) 28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christena Weil

(a) RESIDENCE NO. Cooks Lane ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced~~, (write the word): Widow

5a-If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Oct 6-1838

7 AGE — Years: 85 — Months: 0 — Days: 8 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo Weil

(Address): Cooks Lane

15 Filed ..... 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1923, to Nov 14, 1923,

that I last saw h-r alive on Nov 14, 1923,

and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - myocarditis

Chronic interstitial nephritis

High blood pressure

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage - paralysis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Miller & Hubbard, M. D.

Nov 15/23, 19 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK Cemetery — DATE OF BURIAL: 11/17 1923

20 UNDERTAKER: Geo Lembach & Son — ADDRESS: 2478 W Pratt St

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 16 1923 Robert P. Harrison, Registrar Permit Clerk

Cor.—1-12-23—M&T—100 Bks.

D 80884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80884

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Benjamin Trainor or Trainum

(a) RESIDENCE NO. 808 E. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Hess
(Address) 511 N. Gay St.

15 Filed , 192 Robert F. Harrison, Registrar

NOV 16 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Coates, M. D. (Coroner.)

Nov 16 23 92 (Address) 5308 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. Via American Express — DATE OF BURIAL Nov 16 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 80885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80885

CERTIFICATE OF DEATH.

X 100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 559 W. Biddle St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Alston

(a) RESIDENCE NO. 559 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) (Infant)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Summar

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Pauline alston

13 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

14 Informant Pauline Alston
(Address) 559 W. Biddle St.

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. C. Hennessy, M. D.
(Coroner)

Nov. 16, 1923 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	11/17 1923
20 UNDERTAKER	ADDRESS
Saml J. Hamsley	1 Bidd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert P. Garrison,
Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30886

CERTIFICATE OF DEATH.

31 D 30886

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Calhoun ST., 16 WARD)

2-FULL NAME Addine M. Jackson

(a) RESIDENCE NO. 817 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July-8-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	37	4	6	

8 OCCUFATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Elijah Jackson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma Martin

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lillian Hawkins
(Address) 817 N. Calhoun St.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1923, to Nov 14, 1923,

that I last saw h[illegible] alive on Nov 14, 1923

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Coronar delatation and decompensation

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Mitral stenosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harry S. McCarty, M. D.

11-16 1923 (Address) 607 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11/17 1923

20 UNDERTAKER David Hemsley

ADDRESS 5[illegible] N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 16 1923

Robert P. Harrison,
Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*. or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80887

CERTIFICATE OF DEATH.

90 D 80887

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4307 Groveland ST., 28 WARD)

2-FULL NAME Emily E Pratt

(a) RESIDENCE NO. 4307 Groveland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? 28 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Chas M. Pratt

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	79	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Havre De Grace Md

PARENTS

10 NAME OF FATHER Alexander Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Sutor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Chas E Madeira
(Address) 4307 Groveland Ave

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY That I attended deceased from Mar , 1923, to Nov 16 , 1923, that I last saw her alive on Nov 16 , 1923, and that death occurred, on the date stated above, at 4:20 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) One yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No test

(Signed) E. K. Jump M. D.

, 1923 (Address) 841 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 19 19 23
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 21 1923

Robert P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80888

CERTIFICATE OF DEATH.

D 80888

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 125 (St.) Spalding Ave (Ward) 27

2-FULL NAME Francis McFadden

(a) RESIDENCE NO. 125 Spalding Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sarah A. McFadden

6 DATE OF BIRTH (month, day, and year): April 19-1849

7 AGE — Years: 74 — Months: 6 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 3 years

(c) Name of employer: Poole Eng. & Machine Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Cornelius McFadden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Keziah Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Florence M. Counts

(Address): 125 Spalding Ave.

15 Filed NOV 7 1923, 19

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6th, 1923, to Nov 15, 1923,

that I last saw him alive on Nov 15, 1923,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Known (duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Senile arteriosclerosis

(duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. H. Warfield, M. D.

11/16, 1923 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Nov. 17 1923.

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Hollins St.

Spec. 1-10-21—M&T—1500 Blks.

D 80889

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80889

CERTIFICATE OF DEATH.

164

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1822 N Collington Ave (ST.) 8 (WARD)

2-FULL NAME Casper Alt

(a) RESIDENCE NO. 1822 N Collington Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Alt

6 DATE OF BIRTH (month, day, and year) April 21, 1843

7 AGE — Years: 80 — Months: 7 — Days: 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Nellie Bluse

(Address) 1822 N Collington Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 . 1923 to Nov 16 . 1923.

that I last saw him alive on Nov 16 . 1923

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Ernst C Schwerk M. D.

Nov 16 . 1923 (Address) 928 N Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 17. 1923

20 UNDERTAKER: H. Cook — ADDRESS: 504 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 7 1923 Robert P. Harrison Deputy Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D 80890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 80890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp 12 ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lizzie Moulsdale

(a) RESIDENCE NO. 2650 Huntington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Moulsdale

6 DATE OF BIRTH (month, day, and year): ? 1869

7 AGE — Years: 54 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Robert Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Copeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Lizzie Todd

(Address): 2650 Huntington Ave

15 Filed . . 19 Registrar

NOV 17 1923

ROBERT P. HARRISON, CLERK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11 — 15 1923

17

I HEREBY CERTIFY, That I attended deceased from 9 — 17, 1923, to 11 — 15, 1923,

that I last saw her alive on Nov. 15, 1923,

and that death occurred, on the date stated above, at 11:20A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulm. Tuberculosis

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A C Monnunger M.D.

11-16 1923 (Address) St Jos. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cathedral — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Wm Cook For E Trost — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 80891

CERTIFICATE OF DEATH.

D 80891

REGISTERED NO. Unknown

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 113 Church Av (St.) (Ward) 26

2-FULL NAME Rudolph Lewis Haigis

(a) RESIDENCE No. 113 Church Av St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 14-23

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Rudolph Lewis Haigis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Rudolph L Haigis (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov 16, 1923

that I last saw him alive on Nov 15, 1923

and that death occurred, on the date stated above, at 1/4 m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

at 7th Month

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

Nov 16 23 (Address) 222 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov. 17 1923

20 UNDERTAKER: George L. Schmab

ADDRESS: 2101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 17 1923

Burial Permit Clerk

Spec. 1-10-21 M&S 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 14 05 B 80892

CERTIFICATE OF DEATH.

45 B 80892

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Morris Strickler

(a) RESIDENCE NO. 219 N. Pace St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Daisie Strickler

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Moulder

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Strickler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Bally McDannell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant: Record

(Address): John Hopkins Hosp

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923 to Nov 16, 1923.

that I last saw him alive on Nov 16, 1923.

and that death occurred, on the date stated above, at 12-40 8 m.

The CAUSE OF DEATH* was as follows: Sarcoma duodenum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 31 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Frank Reichert M.D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York PA — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 E. ...

NOV 17 1923 Robert F. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80893

D 80893

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. 19 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Joseph Emmale Muse

(a) RESIDENCE NO. 1520 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt. 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divoreed
HUSBAND of ~~(or) WIFE of~~ Lara Travers

6 DATE OF BIRTH (month, day, and year) Dec. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Orleans La
(State or country)

PARENTS

10 NAME OF FATHER Alex Bayly Muse

11 BIRTHPLACE OF FATHER (city or town) La
(State or country)

12 MAIDEN NAME OF MOTHER Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Robert L Brooks
(Address) 175 Calhoun St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Nov 16, 1923, that I last saw him alive on Nov 16, 1923, and that death occurred, on the date stated above, at 2 42 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach with Metastases to brain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of (?) UPI.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Harper M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/16 1923

20 UNDERTAKER Robert Brookes Son

ADDRESS Cor Calhoun Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES may be important. See instructions on back of certificates.

NOV 17 1923

Robert P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 80894 167633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80894

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Ada Marie Barnes

(a) RESIDENCE NO. 576 Oxford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Ellen Duker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant

(Address) OHNS

15 Filed ....., 19 ..... Registrar

Robert P. Garrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1923, to November 10, 1923, that I last saw h alive on November 10, 1923, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity,

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Edward H. Kemper, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS

WM. A. WOODALL

NOV 10 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 17 1923

0874

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80895

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 80895

CERTIFICATE OF DEATH. 144

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 21 E Mar St. 23 WARD)

2-FULL NAME Florence E Carey.

(a) RESIDENCE. No. 21 E Mar St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martin J Carey

6 DATE OF BIRTH (month, day, and year) Jan. 29 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0.37

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick O Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emma Hartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martin Carey
(Address) 21 E Mar St

15 Filed . 19 . Robert P. Harrison, Registrar

NOV 7 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 16, 1923, that I last saw her alive on Nov 14, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis
Toxemia of pregnancy

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary) Post partum hemorrhage

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Will Beigler, M. D.

11/10, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 11-20 1923

20 UNDERTAKER: E B Slade — ADDRESS: 115 E Mar St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80896

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1503 Eutaw Place ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Roler

(a) RESIDENCE NO. 1503 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Roler

6 DATE OF BIRTH (month, day, and year): Sept 30th 1834

7 AGE — Years: 89 | Months: 1 | Days: 16 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Isaac Neuberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs L Strines

(Address): 1503 E. P.

15 Filed ....., 19 ..... Registrar

NOV 7 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1923, to Nov 15, 1923, that I last saw h[illegible] alive on Nov 15, 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of femur

followed by hypostatic pneumonia

(duration) days mos 4 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Harry Adler M. D.

, 19 (Address) 1718 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai — DATE OF BURIAL: Nov 18th 1923

20 UNDERTAKER: L David Sondheim — ADDRESS: 118 W Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80897

100-001 D 80897

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Joseph Campbell

(a) RESIDENCE NO 1834 E.Eager St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) June 22/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md.

PARENTS

10 NAME OF FATHER Joseph Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Carrie Campbell
(Address) 1834 E.Eager St

15 Filed ..... 192 ..... Registrar

NOV 7 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thoracic Ricketts

(Autopsy at hospital)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. McCollum, M. D.
(Coroner.)

Nov 15/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Joseph T.H.Rochester — ADDRESS 1413 ½ ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1675/15 ID 80898 — ID 80898 — 100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH John Hopkins Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 11 ST., WARD)

2-FULL NAME William Edward Scott

(a) RESIDENCE NO. 1302 Rutter St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: Black — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 16, 1922

7 AGE — Years: 1 — Months: 7 — Days: — — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mollie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records (Address) John Hopkins Hosp

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923 to Nov 16, 1923

that I last saw him alive on Nov 16, 1923.

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, Primary.

(duration) ... yrs. mos 12 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Oscar Tarroff M. D.

11/16, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W.V. Auburn — DATE OF BURIAL 11/17 1923

20 UNDERTAKER: James H. Lewis — ADDRESS 1203 Freeman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 1923 Robert L. Bayne Clerk
Baltimore Circuit Court

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80899

1-001 ✓ B 80899

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Robinson ST., 1 WARD)

2-FULL NAME Howard A. Streckfus

(a) RESIDENCE NO. 802 S. Robinson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? 18 yrs. 9 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Jan 20/05

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	18	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Draftsman

(c) Name of employer Con. Gas. & El. Co

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry G. Streckfus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Fehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Streckfus
(Address) 802 S. Robinson St

15 Filed NOV 17 1923, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1923, to Nov 15, 1923, that I last saw h~~im~~ alive on Nov 15, 1923 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) .....
(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Blood, Symptoms

(Signed) D. T. Smith, M. D.

19 (Address) 3015 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov 18 1923

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80900

CERTIFICATE OF DEATH.

90 D 80900

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1527 Bolton ST., 14 WARD)

2-FULL NAME John Murdoch

(a) RESIDENCE NO. 1527 Bolton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Howard Law

6 DATE OF BIRTH (month, day, and year) March 23rd 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alexander Murdoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Susan Tumbull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary Murdoch (Address) 1527 Bolton St

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29th 1923 to Nov. 16th 1923.

that I last saw h[illegible] alive on Nov. 15th 1923,

and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Coronary Disease,
(Angina Pectris)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) abt yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. S. Lockwood, M. D.

11/17/1923 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 19 1923
20 UNDERTAKER	ADDRESS
Hugg & Jenkins Lane Co	1900 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80901

CERTIFICATE OF DEATH.

89

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 946 Harford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Catherine L. Colford

(a) Residence No..... 946 Harford Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-7 yrs. / mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Wm. Mitchell

6-DATE OF BIRTH (month, day and year) Oct. 29, 1858

7-AGE. 65 yrs. ..... mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House work

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Colford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ellen Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mary Ellen Kelly

(Address) 946 Harford Ave

15-

Filed..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/16/23

17- I HEREBY CERTIFY, That I attended deceased from 11/12/23, 1923, to 11/16, 1923, that I last saw h.. alive on 11/15, 1923 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Dr Edward Wells M. D.

11/16, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL, Nov 18 1923

20-UNDERTAKER. Elmer W. Conklin ADDRESS 924 E. Eager St.

Robert T. Harrison,

NOV 17 1923

WHITE—CAUSES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80902

D 80902

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 S. Poppleton, ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha V. Pedrick,

(Residence in Baltimore: No. 111 S. Poppleton St St.; 5-1 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. July 14, 1842 (Month) (Day) (Year)

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. — Spedden

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. F. Pierpoint

(Address) 902 W. Lombard St

15-

Filed ....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Nov. 15, 1923, that I saw her alive on Nov. 15, 1923, and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Thos. Fenton M. D.

11/17, 1923 (Address) 856 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 111 S. Poppleton St

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Nov. 17, 1923.

20-UNDERTAKER Harry H. Weitzel

ADDRESS 153 W Lombard St

NOV 17 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80903 X 143-002 D 80903

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) ST. 4 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Margaret Buckingham

(a) RESIDENCE NO. Doyle Ave Westminster ST., WARD Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ mos. 2 ds. How long in U. S., if of foreign birth? , yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	26	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos Dell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marg. Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Husband N. Barry Buckingham

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16 .1923. to Nov. 17 .1923.

that I last saw her alive on Nov. 17 .1923.

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows: Ruptured Ectopic Pregnancy

(duration) few hours yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 17. 23

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) [illegible] M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gamber Md

DATE OF BURIAL Nov 19 1923

20 UNDERTAKER H M Routson

ADDRESS 223 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80904

CERTIFICATE OF DEATH.

109-002 D 80904

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Eastern Ave ST. 17 WARD)

2-FULL NAME William Jordan

(a) RESIDENCE No. 1708 Eastern Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 16 1923

7 AGE: Years | Months: 5 | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Mandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Jordan
(Address) 1708 Eastern St.

15 Filed ..... 19 .....
Registrar

NOV 7 1923

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1923, to Nov 15, 1923, that I last saw him alive on Nov 15, 1923, and that death occurred, on the date stated above, at 9 30 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to acute tonsillitis and cervical adenitis

(duration) yrs. mos 3 ds

CONTRIBUTORY (Secondary) Acute asphyxia & tonsillitis & adenitis (duration) yrs. mos. 3 ds

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Ted Hall, M. D.

. 19 (Address) 2126 Fidel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 1727 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80905

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospi ST., 6 WARD)

2-FULL NAME Bertha Goldsboro

(a) RESIDENCE NO. 1710 Mullikin st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 8 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Goldsboro

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Sam Jeffridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M. C. H.

15 Filed NOV 17 1923, 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1923, to Nov. 15, 1923,

that I last saw her alive on Nov. 15, 1923,

and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

11-15-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westbury Cem	11/18 1923
20 UNDERTAKER	ADDRESS
Jas. Jr. Likimas	622 E. Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Oc TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80906

CERTIFICATE OF DEATH.

90 D 80906

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 E. 30th Street ST. 7 WARD)

2-FULL NAME Ammanda Fugate

(a) RESIDENCE NO. 1628 E. Madison St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Fugate

6 DATE OF BIRTH (month, day, and year): July 4, 1848

7 AGE: Years 75 Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Isaac Van Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): George A. Van Horn 513 E. 30th Stuet

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1923, to Nov 16, 1923.

that I last saw her alive on Nov 16th, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Cerebral Hemorrhage (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Wilson Mark M. D.

19 (Address) 3006 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 11/19 1923

20 UNDERTAKER: Albert L Hiltz Jr

ADDRESS: 1606 N Chester St

NOV 17 1923 Robert F. Garrison, Health Board Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80907 ✓ D 80907

X 113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Robert Nauss

(a) RESIDENCE NO. 605 Cumberland St., Harrisburg, Pa
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: wh

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): July 12, 1923

7 AGE — Years: — Months: 4 Days: 5 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: David Nauss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mana Hess.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Record Johns Hopkins Hosp.

15 Filed ..... 19 ..... Registrar

NOV 17 1923

Robert F. Harrigan
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Nov. 17, 1923, that I last saw him alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (not dysentery)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harrisburg, Pa

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. H. Mreech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisburg Pa. — DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Robt S Tittle — ADDRESS: 300 Chambersburg

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80908 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80908

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1824 Pennsylvania Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Kelian.

(a) Residence No. 1824 Pennsylvania Ave St., Ward.

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ HUSBAND of ~~her~~ WIFE of Geo H Kelian

6-DATE OF BIRTH (month, day and year) May 5 184[illegible]

7-AGE. 80 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, John Ament

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Schmidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-(Informant) Mrs Eliz K Romoser

(Address) 1824 Pennsylvania Ave

15-Filed ..... 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923 to Nov 16, 1923

that I last saw her alive on Nov 16 1923

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Elmer B Freeman M. D.

, 19 (Address) 412 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Pauls (Violetville) DATE OF BURIAL. 11-19, 1923

20-UNDERTAKER. Mrs Chas A G Robbe ADDRESS c/o M. Arlington Ave

N. B.—WHITE PAPER. WRITE PLAINLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 7 1923 Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 80909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80909

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 Loudon Ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis G. Boyce

(a) RESIDENCE NO. 120 Loudon Ave ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie A. Boyce

6 DATE OF BIRTH (month, day, and year) July 8, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Highways Dept.

(c) Name of employer Baltimore City, Md.

9 BIRTHPLACE (city or town) Plainfield

(State or country) New Jersey

PARENTS

10 NAME OF FATHER William F. Boyce

11 BIRTHPLACE OF FATHER (city or town) Newark

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Margaret Coriell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Jersey

14 Informant Mrs. Bessie A. Boyce

(Address) 120 Loudon Ave.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1923, to Mar 16, 1923, that I last saw him alive on Mar 16, 1923 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

Mar 19 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Plainfield N J — DATE OF BURIAL Mar 19 1923

20 UNDERTAKER Joseph B. Cox — ADDRESS 1003 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80910

CERTIFICATE OF DEATH

1923 34 v 9

X111-00 b 80910

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gamma

(a) RESIDENCE NO. New York ST., N.Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Gamma

6 DATE OF BIRTH (month, day, and year): Mch-17-1889

7 AGE — Years: 34 Months: 8 Days: 0 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: News Dealer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Trenton N.J.

PARENTS

10 NAME OF FATHER: Frank Gamma.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Madaline Gate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Madeline Gamma

(Address): New York. N.Y.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1923, to Nov 17, 1923, that I last saw him alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 8A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Injarction

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Gaetano Pandolfo, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York N.Y. DATE OF BURIAL: 11/19/23.

20 UNDERTAKER: H E Hughes ADDRESS: 4114 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastric Ulcer

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 80911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 80911

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2128 E. Lombard St., St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Kaplan

(a) Residence No. 2128 E. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Kaplan

6-DATE OF BIRTH (month, day and year): April 14th, 1886

7-AGE: 37 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS:

10-NAME OF FATHER: Harney Kaplan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Hinda --

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant): J. Lewis

(Address): 1439 E. Balto. St.,

15- Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-16-23

17- I HEREBY CERTIFY, That I attended deceased from June, 1922 to Nov 16, 1923

that I last saw him alive on Nov 16, 1923

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pul. tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive Sputum

(Signed) Jack Levin M. D.

Nov 17, 1923 (Address) 2231 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer's Woodlawn

DATE OF BURIAL: 11/18, 1923

20-UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

N. B.—WHITE PLAINLY, WRITE SURNAME FIRST. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 80912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 80912

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3433 Park Heights Ave., St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Kerber

(a) Residence No. 3433 Park Heights Ave., St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Rigina Kerber

6-DATE OF BIRTH (month, day and year): 1863

7-AGE: 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Designer

(b) General nature of industry, business, or establishment in which employed (or employer): 00

(c) Name of employer: 0

9-BIRTHPLACE (city or town) (State or Country): Austria

PARENTS.

10-NAME OF FATHER: Mendel Kerber

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria

11- (Informant) J. Lewis

(Address) 1439 E. Balto. St.,

15-

Filed ..... 192 .....

Registrar.

NOV 19 1923 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-16-23

17- I HEREBY CERTIFY, That I attended deceased from July 28 1923 to Nov. 16 1923.

That I last saw him alive on Nov. 16 1923

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj. Kadry M. D.

1923 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 11/18 1923

20-UNDERTAKER: Jack Levis

ADDRESS: 1439 E Balto St

N. B.—WRITE PLAINLY. Words such as one, two, three, etc., should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80913

CERTIFICATE OF DEATH.

117

D 80913

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital Monument & Rutland Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David Solomon

(a) RESIDENCE NO. 1817 Ruxton ave ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elzeketta Solomon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balt St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1923, to Nov 16, 1923,

that I last saw him alive on Nov 16, 1923,

and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

10 hrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured Appendicitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 9/1923.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

11/16/1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 11/18 1923

20 UNDERTAKER Jack Lewis 1439

ADDRESS E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 80914

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N. Chester — ST.: 6 WARD)

2-FULL NAME Simon Chupricke.

(a) RESIDENCE. No. 14 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mandel Chupricke

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	40	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Baltimore

15 Filed ... 19... Registrar

NOV 18 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Nov 16, 1923, that I last saw him alive on Nov. 16, 1923, and that death occurred, on the date stated above, at 9. 9. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Clavicle

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases & Pulmonary Edema.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes. Date of Oct. 12, 1923

Was there an autopsy? no.

What test confirmed diagnosis? Sections & Smears

(Signed) Benjamin M. Zoppe, M. D.

Nov., 1923 (Address) 2028 E. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Intarnal — DATE OF BURIAL 11/18 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 80915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80915

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 817 Bonn ally ST., 18 WARD)

2-FULL NAME Mary Miller

(a) RESIDENCE NO. 817 Bonnally ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 9 1886 Dont know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 10
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Richard Morgan

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ed E Smith
(Address) 238 Dooley st

15 Filed ..... 192 ..... Registrar

ROBERT R. KRAUTER,
AUG 18 1923
BUREAU VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~Inquest, autopsy or inquiry.~~ Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (duration) ..... yrs. Dont Know mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Jones M. D.
(Coroner.)

11-17, 1923 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-20 1923
20 UNDERTAKER Geo F. A. Gibson	ADDRESS 1735 Lund Ave

D 80916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80916

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 Ryan St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Bruce

(Residence in Baltimore: No. 903 Ryan St.; yrs., 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: house work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr John Bruce

(Address) 903 Ryan St

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

NOV 1 1923 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: November 16th (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright Disease

(Duration) yrs. mos. ds.

(Signed) H. Estelle Black M. D.

(Coroner.)

192.. (Address) 1423 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Nov. 19 1923

20-UNDERTAKER: John F. Cowan & Son ADDRESS: 901 Gilmor St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80917

CERTIFICATE OF DEATH.

161-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Shakespeare ST., V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mat Demski

(a) RESIDENCE NO. 1623 Shakespeare ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 17-23

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mat Demski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Glenka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia Pa

14 Informant Mat Demski
(Address) 1623 Shakespeare St

15 Filed ..... 19 .....
ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923, to Nov 18, 1923,

that I last saw h alive on ....., 19 .....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) asthenia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thos A Bullock, M. D.

, 1923 (Address) 1623 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Nov 18 1923

20 UNDERTAKER F W Ozarowski — ADDRESS Eastern Ave

NOV 18 1923 Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80918

CERTIFICATE OF DEATH.

45 B 80918

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4502 Springdale ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Austin S. C. Lennon

(Residence in Baltimore: No. 4502 Springdale St.; ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-[redacted], [redacted], WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH: Nov. 8th 1858 (Month) (Day), 1 (Year)

7-AGE: 65 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired bank Official
(b) General nature of Industry, business, or establishment in which employed (or employer): ditto

9-BIRTHPLACE, (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Dr. George A. Lennon

11-BIRTHPLACE OF FATHER (State or Country): UNKNOWN

12-MAIDEN NAME OF MOTHER: Susanna Clarke

13-BIRTHPLACE OF MOTHER (State or Country): Dover, England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Marion Hildabrandt

(Address): 4502 Springdale Ave.

15-

Filed ....., 191.... Registrar.

NOV 18 1923 ROBERT R. KRAUTER Social Personnel

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: November (Month) 16. (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1923, to Nov 16- 1923, that I saw him alive on Nov 15- 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Skilling M. D.

Nov. 17..., 1923 (Address) 11 Za. St. Bmld.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Bethel Cemetery Harford Co. Md.

DATE OF BURIAL: Nov. ..., 1923

20-UNDERTAKER: H. E. Hughes, 454 N. Broadway.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 80919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 80919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cole

(a) RESIDENCE NO. 2228 Cambridge st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Bertie~~ Julia M. Cole

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed NOV 1 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1923, to Nov. 16, 1923, that I last saw him alive on Nov. 16, 1923, and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pericarditis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. C. Kelly, M. D.

11-16-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov 19 1923

20 UNDERTAKER Wendell Diffel & Son — ADDRESS 378 N

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80920

CERTIFICATE OF DEATH.

74-001

D 80920

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 E Chase St; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Rochester

(Residence in Baltimore: No. 1842 E Chase st St.: 62 yrs., 5 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 3 (Day), 1861 (Year)

7-AGE,	If LESS than 1 day,
62 yrs. 5 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 162

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Rochester

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Julia A Jones

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gertrude Rochester

(Address) 1842 E. Chase St.

15-

Filed....., 191.....

NOV 8 1923 HUBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Nov 17 1923

that I saw h[illegible] alive on Nov 16 1923

and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypostatic pneumonia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. ds.

(Signed) Geo. T. Dawson M. D.

11-17, 1923 (Address) 1254 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park

DATE OF BURIAL, Nov 19 1923

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 80921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80921

CERTIFICATE OF DEATH.

58-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Darley ave ~~St.~~ 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace P. Kirby

(a) RESIDENCE. No. 1701 Darley ave ~~St.~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES made on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thomas B Kirby

6 DATE OF BIRTH (month, day, and year) Sept 14th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne's Co (State or country) Md

PARENTS

10 NAME OF FATHER Edmond B Palmer

11 BIRTHPLACE OF FATHER (city or town) Queen Anne's Co Md (State or country)

12 MAIDEN NAME OF MOTHER Elma Carmine

13 BIRTHPLACE OF MOTHER (city or town) Queen Anne's Co Md (State or country)

14 Informant Thomas B Kirby

(Address) 1701 Darley ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1923, to Nov 16th, 1923, that I last saw her alive on Nov 16th, 1923, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) L. McC Parker M. D.

Nov 17th, 1923 (Address) 111 E Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Michaels Md	Nov 20th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80922

CERTIFICATE OF DEATH.

66 B 80922

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

2-FULL NAME Joseph F. Stenger

(a) RESIDENCE NO 2620 E. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Oct 20/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35		16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Broom- Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John B.Stenger

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary K. Bobunuk

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Jacob Stenger
(Address) 3410 Phila Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wall, M. D.
(Coroner.)

Nov 17/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Nov. 19 1923.

20 UNDERTAKER Kelly and Ziler.

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 18 1923 Burial Permit

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80923

CERTIFICATE OF DEATH.

31 D 80923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S. WOLFE STREET ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY SCZEMPEK

(a) RESIDENCE NO. 122 S. WOLFE STREET ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Szczempek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catharn Boras

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Cath Szczempek

(Address) 122 S Wolfe

15 Filed ..... 19 ..... Registrar

NOV 18 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1923 Nov. 15.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923 to Nov. 15, 1923,

that I last saw her alive on Nov. 15 1923,

and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? sputum

(Signed) William J Kaweski M. D.

Nov. 16 (Address) 801 N. KENWOOD AVENUE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Nov 19 1923

20 UNDERTAKER Wm J Jaskowski

ADDRESS 1515 Eastern

Spec.—1-10-21—M&T—1500 Bks.

D 80924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D 80924

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Hartford Ave ST., 9 WARD)

2-FULL NAME Walter J Wrzisinski

(a) RESIDENCE No. 1624 Hartford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Walter Wrzisinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Cyras

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Walter Wrzisinski
(Address) 1624 Hartford Ave

15 Filed ..... 19 .....

NOV 18 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov 17, 1923.

that I last saw him alive on Nov 6, 1923

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

unknown (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) Thomas Tolan, M. D.

11/18, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Nov-19 1923
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	1005 Monument Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Handrejch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80925

74-001 D 80925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 Ashland Ave ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Handrejch

(Residence in Baltimore: No. 2038 Ashland Ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Hajl

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Unknown

(Address) 1035 Cathedral

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 16, 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1913, to Nov 16 1913, that I saw h[er] alive on Nov 16 1913, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. 2 mos. 1 ds.

(Signed) Wm. R. Lamdin M. D.

Nov 17, 1913 (Address) 20 W. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov 18, 1913.

20-UNDERTAKER Frank E. Mach Son — ADDRESS 1916 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 18 1913 ROBERT R. KRAUTER Burial Permit Clerk

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80926

CERTIFICATE OF DEATH.

100-001 ✓

D 80926

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Locust & Oak ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Levy

(Residence in Baltimore: No. Locust & Oak (Or Usual St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Oct 28, 1918
(Month) (Day) (Year)

7-AGE, 5 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Joseph Levy

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Catherine Weisel

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Levy

(Address) Locust & Oak

15-

NOV 18 1923 ROBERT H. KRAUTER, Burial Permit

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 16, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1923, to Nov 16 1923, that I saw h[illegible] alive on Nov 16 1923, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert Webster M. D.

Nov 17 1923 (Address) 703 Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Nov 19, 1923

20-UNDERTAKER	ADDRESS
Frank Eyerdam	906 Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

Johnnie Leadbetter

16774

HEALTH DEPARTMENT—CITY OF BALTIMORE

80927

CERTIFICATE OF DEATH.

X 84 80927

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnnie Leadbetter

(a) RESIDENCE NO. Round Rock, Texas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. ——— mos. 2 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) — 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	?	?	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ———
(State or country) Texas

PARENTS

10 NAME OF FATHER John Leadbetter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Texas

12 MAIDEN NAME OF MOTHER Katie Wallace

13 BIRTHPLACE OF MOTHER (city or town) ———
(State or country) Texas

14 Informant Record
(Address) Johns Hopkins Hospital

15 Filed NOV 18 1923, 19 ..... Registrar

ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to Nov. 17, 1923, that I last saw h[illegible] alive on Nov 17 - 1923, and that death occurred, on the date stated above, at 10 5/8 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Glioma

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Texas.

Did an operation precede death? Yes Date of 11-17-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Firor, M. D.

11/18, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Round Rock Texas

DATE OF BURIAL 11/18 1923

20 UNDERTAKER H E Hughes

ADDRESS 424 N. Broadway

Spec. 1-10-21 M-2 (1500 Blks.

1693

HEALTH DEPARTMENT—CITY OF BALTIMORE

1693 B 80928

159-003 B 80928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE (No. ..... ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Adornato

(a) RESIDENCE NO. 638 S. 14th St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Mar. 24 1923

7 AGE — Years: — Months: 7 Days: 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ernest Adornato

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Stellace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Record

(Address): Johns Hopkins Hosp

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923 to Nov 16, 1923.

that I last saw ~~him~~ alive on Nov 16, 1923.

and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Congenital cystic hygroma neck, right.

(duration) yrs. 7 mos 22 ds.

CONTRIBUTORY (Secondary) operative shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Nov. 16, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Warfield M Jones, M. D.

1917, 1923 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Nov. 19 1923

20 UNDERTAKER: Wm C. Black ADDRESS: 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80929

CERTIFICATE OF DEATH.

100-01 80929

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4005 Garrison Ave ST., 15 WARD)

2-FULL NAME Barbara Hart Godden

(a) RESIDENCE NO. 4005 Garrison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 6 1916

7 AGE — Years: 7 — Months: 1 — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Norwalk Conn

PARENTS

10 NAME OF FATHER: Alym Godden

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Y

12 MAIDEN NAME OF MOTHER: Mildred Estrada

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Y

14 Informant (Address): Alym Godden 4005 Garrison Ave

15 Filed ..., 19... Registrar

NOV 19 1923 ROBERT R. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 17, 1923, that I last saw her alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 8. a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) M. S. Schemmel, M. D.

, 19 (Address) 3107 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: South Norwalk Conn — DATE OF BURIAL: Nov 19 1923

20 UNDERTAKER: H. J. Lucknell Sons — ADDRESS: Walk

Spec. 1-10-21 M&T 1500 Blks.

16744

D 80930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. WARD)

2-FULL NAME John Fernandis

(a) RESIDENCE NO. 1401 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Fernandis

6 DATE OF BIRTH (month, day, and year): Oct 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Fernandis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Shade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 -, 1923 to Nov 16 -, 1923.

that I last saw him alive on Nov 16 -, 1923.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Nov 16 '23

Was there an autopsy? Yes

What test confirmed diagnosis? X ray & Autopsy

(Signed) F. L. Rachford M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 11-21 1923

20 UNDERTAKER: George T. A. Gibson

ADDRESS: 1733 Druid Hill Ave

Filed ..... 19 ..... Registrar

Robert R. Kramer

Burial Permit Clerk.

Dr Smith, Chestnut Ave. 3429

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80931

CERTIFICATE OF DEATH.

D 80931

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 W 37th St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael McKenzie

(a) RESIDENCE NO. 820 W 37th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 85.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant William F Kenny

(Address) 820 W 37 St.

15 Filed ....., 19 ..... Registrar

NOV 19 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Nov. 18, 1923,

that I last saw he alive on Nov. 17, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 3429 Chestnut Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. H. Amoss, M. D.

Nov 16, 1923 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oella Md	Nov 19 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80932 ✓ D 80932

CERTIFICATE OF DEATH.

124

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) 17 (WARD)

2-FULL NAME Hahmdw Hawlman

(a) RESIDENCE NO. 957 Penna. Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Jan 19, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker 017

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Theodore J Howlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Sommers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theodore J Howlman
(Address) 957 Penna Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1923, to Nov. 16, 1923, that I last saw him alive on Nov. 16, 1923, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff
Terminal Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured gall bladder-fecal fistula (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 957 Penna ave.

Did an operation precede death? Yes Date of Nov. 2, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Operation-

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 20 1923

20 UNDERTAKER Wm Cook & Son — ADDRESS 429 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

O'neill Fulton & Hazlett

D 80933 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80933

CERTIFICATE OF DEATH. 129

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Smallwood ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Sunkes

(a) RESIDENCE No. 425 S. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tel. Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer C & P Tel Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Lewis Sunkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lena Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lena Sunkes

(Address) 425 S. Smallwood

15 Filed ....., 19 .....

ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Nov 17, 1923, that I last saw her alive on Nov 16, 1923 and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

11/18, 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 21 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 Edmondson

Spec.—1-10-21—M&T—1500 Bks.

80934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 80934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1019 N Carey ST. 16 WARD)

2-FULL NAME John Beamon

(a) RESIDENCE No. 1019 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecilia Beamon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer): Ch 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C.

12 MAIDEN NAME OF MOTHER: Ellen Binkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C.

14 Informant: Cecilia Beamon

(Address) 1019 n Cary st

15 Filed ..... 19 ..... Registrar

NOV 19 1923

ROBERT R. KRAUTH

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/15/ 19 23

17

I HEREBY CERTIFY, That I attended deceased from 10/8/ 19 23 to 11/15/ 19 23

that I last saw him alive on 11/15/ 19 23

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

about (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Microscopic

(Signed) J Emmons Cox M. D.

11/16/ 19 23 (Address) 908 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 19 1923

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 2319 Division St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80935

CERTIFICATE OF DEATH.

101-001

D 80935

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Summit Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack R Mullen

(Residence in Baltimore: No. 9 Summit ave St.; 5 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 18 (Day) 1899 (Year)

7-AGE, 24 yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Schauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm Mullen

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Grace Burch

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha H Mullen

(Address) 9 Summit Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1923, to Nov 18 1923, that I saw him alive on Nov 17 1923, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

1st Lar Pneumonia

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Schauffeur

Pneumonia (Duration) — yrs. — mos. 9 ds.

(Signed) Ed D. Ensor M. D.

Nov 18, 1923 (Address) 5016 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Pleasant Cemetery Balto Co. Md

DATE OF BURIAL, Nov 20, 1923.

20-UNDERTAKER John A Mitchell

ADDRESS 1201 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

D 80936 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 80936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Wiley

(a) RESIDENCE NO. 637 W. Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 0860

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Deposit, Md.

PARENTS

10 NAME OF FATHER Wesley Wiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 10, 19 23, to November 14, 19 23,

that I last saw h in alive on November 14, 19 23,

and that death occurred, on the date stated above, at 8:00 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Acute Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude S. Drach, M. D.

11-15-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Nov 19 1923

20 UNDERTAKER John A. Mitchell

ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80937

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Ashland Ave. ST. 10 WARD)

2-FULL NAME Catherine E. Scott

(a) RESIDENCE NO. 1408 Ashland Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulatto

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 10 1923

7 AGE — Years — Months — Days 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER George Scott.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Dobbs

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant M. George Scott.
(Address) 1408 Ashland Ave

15 Filed ..... 19 ..... Registrar

NOV 19 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 —, 1923, to Nov. 17 —, 1923, that I last saw her alive on Nov. 17 —, 1923, and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth, 7 mos. gestation

(duration) — yrs. — mos 7 — ds.

CONTRIBUTORY (Secondary) — (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edwin B. Fenby, M. D.

11/18/1923 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mathews Cemetery — DATE OF BURIAL: Nov 19 1923

20 UNDERTAKER: Henry Hoerle & Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80938

CERTIFICATE OF DEATH.

90

B 80938

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Elliott ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josefa Jakubowski

(a) RESIDENCE NO. 2762 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Mar 19 1859

7 AGE: Years 64 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Walczak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Boleslaw Jakubowski

(Address) 507 S Glover St

15 NOV 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from 10—1—1923 to 11—17—1923

that I last saw him alive on 11—10—1923

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Finding

(Signed) D. F. Huff Jr. M. D.

, 19 (Address) 5004 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Nov 20 1923

20 UNDERTAKER: Stephen J Fialkowski — ADDRESS: 1001 S Kenwood

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80939 ✓ D 80939

D 80939 CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jones

(a) RESIDENCE NO. 6th st Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 1887

7 AGE: Years 35 Months 11 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): ..... O&O

(c) Name of employer .....

9 BIRTHPLACE (city or town) Chattanooga (State or country) Tenn.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant ..... (Address) 2nd st Fairfield

15 NOV 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17 I HEREBY CERTIFY That I attended deceased from Oct 21, 1923, to Nov. 16, 1923, that I last saw him alive on Nov. 15, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... Fairfield

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Marcellus E. Jones, M. D.

, 19 (Address) 1445 N Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Nov 17 1923

20 UNDERTAKER: Commissioner Health.

ADDRESS

WOODALL

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Rheumatism

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80940 ✓ D 80940

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mangren

(a) RESIDENCE No 19 N. Frederick St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 07
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): unknown

PARENTS

10 NAME OF FATHER: "

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant St. Joseph Hospital
(Address)

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. N. Cullen, M. D.
(Coroner.)

Nov 17 23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Nov 17 192 3

20 UNDERTAKER

ADDRESS

NOV 19 1923 ROBERT R. KRAUTER, Commissioner of Health.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80941

CERTIFICATE OF DEATH.

31 D 80941

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (NO. ..... ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Daly

(a) RESIDENCE NO. 1808 N. Washington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Daly

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35 yrs.	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alex. Dlolinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Munks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eugene Daly (Address) 1808 N. Washington St

15 Filed NOV 19 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1923 to Nov. 16 1923.

that I last saw h[illegible] alive on Nov. 16 1923,

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Chr. endocarditis

Bronchial asthma

Tuberculous Colitis (?)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? none.

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	11/19/23
UNDERTAKER	ADDRESS
C. D. Fanning & Son	1938 E. Lafayette Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80942

CERTIFICATE OF DEATH.

161-001

D 80942

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 Monument St. WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Fowler

(a) RESIDENCE NO. 1822 Monument St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 15 1923

7 AGE: Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Geo. A Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Adelaide M Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Geo. A Fowler

(Address) 1822 Monument

15 Filed NOV 19 1923 ROBERT R. MAAS (Burial Permit Clerk.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to , 19 ,

that I last saw h[illegible] alive on Nov 15 1923

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

about 7 months

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L Covert M. D.

Nov 16 1923 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Mt Ethick

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80943

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1307 N Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis X Kreis

(a) RESIDENCE NO. 1307 N Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Peter Kreis

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dorothea Nov 18 1923

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Agnes V Cahyer
(Address) 1307 N. Broadway.

15 Filed NOV 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923, to Nov. 18, 1923, that I last saw h[illegible] alive on " 16, 1923, and that death occurred, on the date stated above, at 5.a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Y

What test confirmed diagnosis? Test for albumen & casts

(Signed) H. H. Hartman, M. D.

(Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemy — DATE OF BURIAL Nov 21 1923

20 UNDERTAKER Roth & Turner Sons — ADDRESS 1442 W. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80944

CERTIFICATE OF DEATH.

49 ✓

D 80944

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 8 WARD)

2-FULL NAME Edda S. Richardson

(a) RESIDENCE NO. 1303 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred W yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Husband~~

6 DATE OF BIRTH (month, day, and year): Aug 3 - 1867

7 AGE: Years 56 Months Days

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mary E. Richardson

(Address) 1303 N. Bethel St.

15 Filed ..... 19 ..... Registrar

NOV 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923 to Nov. 17, 1923.

that I last saw h[illegible] alive on Nov. 17, 1923,

and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos 1 d.

CONTRIBUTORY (Secondary) Carcinoma of pancreas (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Harold C. Fellsburg M.D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pakwood Cemetery

DATE OF BURIAL: Nov. 19 1923

20 UNDERTAKER: Robt Turner Inc

ADDRESS 1747 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80945

D 80945

CERTIFICATE OF DEATH.

31 V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wilbain Cannon.

(a) RESIDENCE NO. 112 Smallwood St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1921

7 AGE: Years | Months: 18 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Eva Sample

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hospital Record.

15 Filed NOV 9 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/12/23 19

17

I HEREBY CERTIFY, That I attended deceased from 10/9/23 19 11/12/23 19

that I last saw h[illegible] live on 11/12/23 19

and that death occurred, on the date stated above, at 12, 00 P. m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

ventr Milary Tuberculosis.

9

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley M. D.

19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery

DATE OF BURIAL: Nov 12 1923

20 UNDERTAKER: Mrs Robert Stitt

ADDRESS: 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 80946

HEALTH DEPARTMENT—CITY OF BALTIMORE

001 ✓

D 80946

CERTIFICATE OF DEATH.

167

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 501 N. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... John Glenday Wauden

(Residence in Baltimore: No. 501 N. Calhoun St.; 25 yrs., 1 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. Sept. 30, 1898
(Month) (Day) (Year)

7-AGE. 25 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Edmund S. Wauden

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Anna M. Ward

13-BIRTHPLACE OF MOTHER, (State or Country). Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Stuart Wauden

(Address) 414 N. Arlington Ave

15-

Filed..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns by gas,
accidental (Illuminating)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov. 17 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park | DATE OF BURIAL. 20 Nov 1923

20-UNDERTAKER. Geo. Smith | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 19 1923 Burial Permit Issued

ROBT. P. KRAUTER

Spec.—1-10-21—M&T—1500 Bks.

D 80947

HEALTH DEPARTMENT—CITY OF BALTIMORE

143-003

D 80947

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 76 WARD)

2-FULL NAME Mrs. Madeline McClintock

(a) RESIDENCE NO. 629 S. 14th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph McClintock.

6 DATE OF BIRTH (month, day, and year): May 12 1894

7 AGE — Years: 29 — Months: 6 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John G. Schrauder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Finlay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ralph McClintock

(Address): 629 S 14th

15 Filed NOV 19 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-18-1923

17 I HEREBY CERTIFY, That I attended deceased from 11-18-23, 19..., to 11-18, 19 23,

that I last saw h. alive on 11-18, 19 23,

and that death occurred, on the date stated above, at 9 25 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage — shock

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Extra-uterine pregnancy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-18-23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry V. P. Wilson M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem

DATE OF BURIAL: Nov 21 1923

20 UNDERTAKER: John Ellrich

ADDRESS: 200 E Oliver

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

80948

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1625 80948

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3306 E. Lombard St. 26 WARD)

REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles H. L. Decker Jr.

(Residence in Baltimore: No. 3306 E. Lombard St. St.; yrs. 1/12 mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED WIDOWED OR DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: November 17, 1923 (Month) (Day) (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day / hrs. or min.? 1/2

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Chas H. Decker

11 BIRTHPLACE OF FATHER (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Geneva N. Schwarz

13 BIRTHPLACE OF MOTHER (State or country): Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas H. L. Decker

(Address) 3306 E Lombard St.

15.

Filed ..... 191 NOV 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 17, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923. to. Nov 17 1923.

that I saw h— alive on Nov 17, 1923.

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... yrs. ..... mos. 1/2 hr

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm A Schneider M. D.

Nov 17, 1923 (Address) 3307 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Nov 17, 1923

20 UNDERTAKER: John Meerich

ADDRESS: 2008 Orleans

B 80949

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 80949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 806 N. 34 St. REGISTERED No. C

CITY OF BALTIMORE (No. 806 N. 34 St. St.; 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly M. Smitson

(Residence in Baltimore: No. 806 N. 34 St. St.; yrs., life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, June 22, 1923
(Month) (Day) (Year)

7-AGE, 0 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto city Md.

PARENTS.

10-NAME OF FATHER, Richard T Smitson

11-BIRTHPLACE OF FATHER (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Brulah V. Lilly

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard T Smitson

(Address) 806 N. 34 st

15- NOV 19 1923

16-Date Rec'd ..... ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above. at 4 am

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. prs Marrisse M. D.
(Coroner)

Nov. 17, 1923 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Savage. Md. DATE OF BURIAL, 11/20, 1923

20-UNDERTAKER J Hall Davis ADDRESS 3307 Paine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80950

CERTIFICATE OF DEATH.

D 80950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 W. Hoffman ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Peace

(a) RESIDENCE. No. 343 W. Hoffman ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If ~~married, widowed, or divorced~~ HUSBAND ~~of~~ ~~WIFE of~~ Sarah Key Peace.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter or Butler

(b) General nature of industry, business, or establishment in which employed (or employer) serving meals

(c) Name of employer Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hattie Johnson

(Address) 343 W. Hoffman St

15 Filed NOV 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10th, 1923, to Nov 16, 1923.

that I last saw h— alive on Nov. 15, 1923.

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary) senile debility

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. Grant Pratt, M. D.

, 19 (Address) 334 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	11/19 1923
UNDERTAKER Samuel D. Hemsley	ADDRESS 1 Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 80951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80951

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 752 George St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Scott

(a) Residence No. 752 George St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Fem	col	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frantony Scott

6-DATE OF BIRTH (month, day and year) Nov. 9 1871

7-AGE. 52 yrs. — mos. 7 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER, Richard Dades

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Mabel Scott
(Address) 752 George St

15- Filed....., 192.. ROBERT R. KRAMER Registrar

NOV 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 16 23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 16, 1923, that I last saw h.r alive on Nov. 16, 1923, and that death occurred, on the date stated above, at 8.45A m.

The CAUSE OF DEATH* was as follows:

Tuber Pneumonia

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Hamilton Magruder M. D.

11/16, 1923 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 11/19, 1923

20-UNDERTAKER: Samuel O'Rourke — ADDRESS 1 Biddle

N. B.—NAME PLAINLY, WITH SURNAME FIRST. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80952

CERTIFICATE OF DEATH.

182 D 80952

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier No. 8 Locust Point ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Hackney.

(a) RESIDENCE NO 725 W. Lexington St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND OF Grace Hackney.

6 DATE OF BIRTH (month, day, and year) July 4, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): Dry dock.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charleston, S.C.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Grace Hackney, (wife)
(Address) 1425 Henry St.

15 Filed NOV 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing November 1, 1923. Body found November 17, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
fall from a wharf.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov. 19, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilden Cemetery	Nov. 19 1923
20 UNDERTAKER: C. J. Black	ADDRESS: 742 W. Northam.

IMPORTANT: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 80953

CERTIFICATE OF DEATH.

D 80953

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME William Burke

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address) HOPKINS ROBERT R. KRAUTER,

15 Filed NOV 19 1923 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to November 15, 1923, that I last saw him alive on November 15, 1923, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Suicide Determination

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Terminal) Bronchio-Pneumonia (duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Claude A. Kerr, M. D.

11-17-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.
Per. Wm. E. WORRALL

ADDRESS NOV 19 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

58

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80954

D 80954

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME Thomas Pedford

(a) RESIDENCE NO. 640 Jaspar St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Md.

PARENTS

10 NAME OF FATHER John Bedford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore, Md.

12 MAIDEN NAME OF MOTHER Alice Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore, Md.

14 Informant Municipal Hospital Records. (Address) ROBERT R. KRAUTER

15 Filed NOV 21 1923 19 0878 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to November 16, 1923, that I last saw him alive on November 16, 1923, and that death occurred, on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Hypertrophy)
Myocardial degeneration

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Claude S Pace, M. D.

11/17/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 48

Spec.—1-10-21—M&T—1500 Bks.

D 80955 ✓ D 80955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST., 28 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Humbler

(a) RESIDENCE NO. Mt Hope Retreat ST., 28 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt 70	~~69~~	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Farmer & Fr

(b) General nature of industry, business, or establishment in which employed (or employer) Farming -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Adams Co Pa

PARENTS

10 NAME OF FATHER David Humbler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Adams Co Pa

12 MAIDEN NAME OF MOTHER Susana Swilli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Adams Co Pa

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 Filed NOV 19 1923 H. D. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1911, to Nov. 15, 1923, that I last saw him alive on Nov. 15, 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart—(Mitral Regurgitation) abt (duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr. Maniacal Psychosis abt (duration) 13 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Adams Co Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt St. Marys Emmittsburg — DATE OF BURIAL Nov 21 1923

20 UNDERTAKER Wm Fletcher Sons — ADDRESS North Pa

Spec.—1-10-21—M&T—1500 Bks.

D 80956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80956

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 322 N Green ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W Sermon

(a) RESIDENCE No. 322 N Greene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Sermon

6 DATE OF BIRTH (month, day, and year) Jan. 25 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	74	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country) Greenbury Sermon

PARENTS

10 NAME OF FATHER Greenbury Sermon

11 BIRTHPLACE OF FATHER (city or town) Boston

(State or country)

12 MAIDEN NAME OF MOTHER Jane Anderson

13 BIRTHPLACE OF MOTHER (city or town) La.

(State or country)

14 Informant Mary Sermon

(Address) 322 N. Green ST.

15 Filed NOV 19 1923 H. Lamson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Nov 18, 1923.

that I last saw him alive on Nov 18, 1923,

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) 2 yrs. 0 mos. 29 ds.

CONTRIBUTORY (Secondary) Pleuritic effusion

(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical signs

(Signed) R B Kempton M. D.

Nov 19 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 21 1923

20 UNDERTAKER W. J. Sickner & Sons ADDRESS North & Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80957 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 80957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. Gen'l. Hospital. 24 127 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Walter Holmes.

(a) RESIDENCE NO. 1426 Covington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula M. Holmes.

6 DATE OF BIRTH (month, day, and year) May 1-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glassworker 686

(b) General nature of industry, business, or establishment in which employed (or employer) Glassblower.

(c) Name of employer Buck Glass Co.

9 BIRTHPLACE (city or town) Washington (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Fred Holmes.

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Keen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs F. W. Holmes. (Address) 1426 Covington St. Balt.

Rec'd NOV 19 1923 H. Lamm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923. to Nov 17, 1923. that I last saw h[illegible] alive on Nov 17, 1923, and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis, followed by General Peritonitis.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General Peritonitis.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? Yes. Date of Nov. 15, 1923.

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno Acampora M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL. 11/21 1923

20 UNDERTAKER L. F. McCully

ADDRESS 130 E. F[illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80958

CERTIFICATE OF DEATH.

129 D 80958

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2557 McCulloh ST. WARD) 13

2-FULL NAME Amelia A. Beyer

(a) RESIDENCE NO. 2557 McCulloh WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced: (or) WIFE of George L. Beyer

6 DATE OF BIRTH (month, day, and year): September 1858

7 AGE — Years: 65 — Months: c — Days: c — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): (HD)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John F. Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Massachusetts

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: George L. Beyer

(Address) 2557 McCulloh St

15 Filed NOV 19 1923, 19 ..... Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1923, to Nov. 17, 1923, that I last saw her alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Grip

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Symptoms and urinary examination

(Signed) J. F. Chenowith, M. D.

Nov 19, 1923 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Nov 20 1923
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80959

CERTIFICATE OF DEATH.

185

D 80959

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 615 N. Collington Ave ST., 1 WARD)

2-FULL NAME Susanna Lotz

(a) RESIDENCE NO. 615 N. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Lotz

6 DATE OF BIRTH (month, day, and year) Sept. 29/1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Schwartzkopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Wunderlich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Lotz
(Address) 2311 McElderry St.

15 Filed Nov 19 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Hypostatic Pneumonia
(History of Chr. Bronshitis for yrs.)
(duration) yrs. Sept 7, 23 mos ds.
CONTRIBUTORY (Secondary) Fell down steps into yard in rear of residence. confined to bed ever since.
(duration) yrs. mos. ds.

(Signed) J. S. N. Totter, M. D.
(Coroner)
Nov 19/23 192 (Address) 500 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 192

20 UNDERTAKER Lilly & Feiler — ADDRESS 1638 Wash Av

MENTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 80960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80960

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 E. Chase ST., 10 WARD)

2-FULL NAME Mary J. Kellus

(a) RESIDENCE NO. 907 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress 069

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna M Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Arthur

(Address) 907 E. Chase St

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1923, to Nov 17, 1923.

that I last saw h alive on Nov 16, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) 3 mos +

CONTRIBUTORY (Secondary) Cancer of Breast removed last May

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jefferies Buck M. D.

(Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov. 20 1923

20 UNDERTAKER H. C. Weidefeld — ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80961

D 80961

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Ag. Hospital St., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barrett C. Smith

(a) RESIDENCE NO. St. Ag. Hospital St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Smith

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
51	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Viola Smith
(Address) Catonsville Md.

15 Filed NOV 19 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto. Accident
Fracture of Skull & Jaw.
(duration) yrs. mos 6 hrs.

CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. 6 hrs.

(Signed) Geo Easton Jr M. D.
(Coroner)
Nov 18, 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Catonsville Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Furn. Co.	Nov 20 1923
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate.

NOV 19 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80962

CERTIFICATE OF DEATH.

D 80962

1. PLACE OF DEATH Johns Hopkins Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO. 14-001

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Essie James

(a) RESIDENCE NO. 1902 Mc Cullough St WARD ..... (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: Black — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Dec 24 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: ~~Macon Ga~~ ~~Maryland~~

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Wellons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Mary Wellons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: Record (Address): Johns Hopkins Hosp

15 Filed NOV 19 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 17, 1923, that I last saw her alive on Nov 17, 1923, and that death occurred, on the date stated above, at 9.00 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia — 2 days

Cerebral Hemorrhage (?)

Hypertension — 6 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) P. P. Truman, M. D.

Nov 17, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 11/20/1923

20 UNDERTAKER: Samuel T Hawley — ADDRESS: Ft Bldg

Spec.—1-10-21—M&T—1500 Bks.

Lindsay — ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80963

CERTIFICATE OF DEATH.

31

D 80963

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 820 S. Decker ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Burns

(a) RESIDENCE NO. 820 So Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Lenora Burns

6 DATE OF BIRTH (month, day, and year) March 17. 1879.

7 AGE — Years: 44 — Months: 8 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Guard

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer: Ft McHenry Hospital

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md Maryland

PARENTS

10 NAME OF FATHER: William M Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? —

12 MAIDEN NAME OF MOTHER: ? Dora

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Lenora Burns (Address) 820 So Decker Ave

15 ... 19 ... Registrar

NOV 19 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov 16, 1923, that I last saw h[e] alive on Nov 16, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) none (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C K Mc Cuskey, M. D.

Nov 21 1923 (Address) 2538 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Cathedral Cemetery — DATE OF BURIAL: Nov 21, 1923

20 UNDERTAKER: Wm Leroy Von E. Kinsey — ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D 80964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80964

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2812 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cassandra M. Crouse

(Residence in Baltimore: No. 2812 Walbrook ave St.; 78 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH July 18 ~~11~~, 1843
(Month) (Day) (Year)

7-AGE, 80 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Housework~~
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Tennessee

PARENTS.

10-NAME OF FATHER, Wm G Roberts

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Ann McCrain

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lucy Wagner

(Address) 2812 Walbrook Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1922 191..., to Nov 17 - 1923 ~~1st~~, that I saw her alive on Nov. 16 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility & arteriosclerosis

..... (Duration) 2 yrs. mos. ds.

(Signed) Thos. H. Shilling M. D.

Nov. 19, 1923. (Address) 2300 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet DATE OF BURIAL, Nov 20, 1923

20-UNDERTAKER Wm Carr's Sons ADDRESS Mt Ave

Robert P. Harrison, Burial Permit Clerk

NOV 19 1923

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUP... important. See instructions on back of certificate.

Spec—12-23-21—E.B R.S.—400 Bks.

D 80965

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 80965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1017 W. Lombard St. St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Amelia J. Lee

(a) Residence No. 1017 W. Lombard St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J Lee

6-DATE OF BIRTH (month, day and year) Dec. 24, 1843

7-AGE. 79 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore,

(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Hugh M. Hardy

11-BIRTHPLACE OF FATHER (city or town) Baltimore

(State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth Degroff

13-BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or Country). Maryland

14- (Informant) Samuel J. Lee

(Address) 26 S. Schroeder St.

15- NOV 19 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1923, to Nov. 17, 1923, that I last saw h[illegible] alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The typical signs & symptoms

(Signed) Charles Lee M. D.

11-19-23 (Address) 1111 W Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery — DATE OF BURIAL. Nov. 20, 1923

20-UNDERTAKER. Cook & Cook — ADDRESS 1003 W. Balto St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 80966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80966

CERTIFICATE OF DEATH.

91-002

19

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1723 W. Pratt St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Henniok

(Residence in Baltimore: No. 1723 W. Pratt St. St.; yrs. 62 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Oct. 14 (Month) (Day) 1844 (Year)

7-AGE, 79 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Michiel Neuberth

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Reifsnider

13-BIRTHPLACE OF MOTHER, (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cecil E. Brown

(Address) 1932 W. Lombard St.

15-

NOV 19 1923

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. C. Bladel M. D.
(Coroner.)

11-19 192 3 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Nov 21st 1923
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Gay St.

(1) Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

(Sibley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80967

D 80967

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 St. Paul's ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Sibley.

1a) RESIDENCE NO. 711 St. Paul's ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8-23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Sibley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia S.C.

12 MAIDEN NAME OF MOTHER Lula Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lula Sibley
(Address) 711 St. Paul's St.

15 Filed NOV 19 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion
Intestinal

(Duration) yrs. mos 1 hr ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. hrs ds.

(Signed) Geo E Bates, M. D.

Nov 19 1923 (Coroner.) (Address) 1456 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 11/20/23

20 UNDERTAKER Samuel Stanley ADDRESS 1 Bell

NOV 19 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Picciotto)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80968 — 101-001 ✓ — D 80968

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1737 Cleft View Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Picciotto

(a) RESIDENCE NO. 1737 Clyftview ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary. Russo.

6 DATE OF BIRTH (month, day and year): Dec. 20/1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47		10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Frank Russo.

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Salvatore Picciotto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Carmela Palma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Mary G. Picciotto

(Address): 1737 Cleft View ave.

15 NOV 19 1923 — Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1923, to Nov 17, 1923, that I last saw him alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 11-45 P. m.

The CAUSE OF DEATH* was as follows:

1 Tobar pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTOR (Secondary): Arter sclerosis Odema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl J. Green M. D.

11-18, 1923 (Address) 120 Risgate, St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cemetery

DATE OF BURIAL: Nov 21 1923

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Hayford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80969

CERTIFICATE OF DEATH.

90

D 80969

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 17 WARD)

2-FULL NAME William J. Moylan

(a) RESIDENCE No. 304 Harwood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Moylan

6 DATE OF BIRTH (month, day, and year): 10/30/1853

7 AGE: Years 70 | Months — | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Moylan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary Moylan 304 Harwood ave

15 Robert P. Harrison, Registrar

NOV 19 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1923, to Nov. 18, 1923, that I last saw him alive on Nov. 18, 1923, and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Terminal Streptococcic Diarrhoea (duration) yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S. - Lab.

(Signed) J. A. Scheurich M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: 11/20/23, 19

20 UNDERTAKER: George J. Ruth

ADDRESS: 1335 Hanford

O. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80970

CERTIFICATE OF DEATH.

89 D 80970

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 N Lexington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia D. Warner

(a) RESIDENCE. NO. 802 N. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 20, 1863

7 AGE — Years: 60 Months: 2 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md.

PARENTS

10 NAME OF FATHER: Robert Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E. Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Md

14 Informant: Harry Warner
(Address) 800 N. Lexington St.

15 Filed ... 19 ... Registrar

NOV 19 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1923, to Nov 15, 1923, that I last saw her alive on Nov 15, 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Kerr Williams, M. D.

(Address) 601 Reservoir Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Hagerstown Md

DATE OF BURIAL: Nov 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D 80971

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home + Hosp. ST., 13 WARD)

2-FULL NAME Mrs Emma Mustard

(a) RESIDENCE NO. 2134 Bolton st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Mustard

6 DATE OF BIRTH (month, day, and year): June 1. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
82	5	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Phila Pa.

PARENTS

10 NAME OF FATHER: James Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Catherine Ryder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Florence M. Shirley

(Address): 2134 Bolton St

15 Registrar: Robert P. Harrison,

Burial Permit Clerk

NOV 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19 1923

17

I HEREBY CERTIFY, That I attended deceased from 11/12/23, 19..., to 11/19/23, 19...,

that I last saw him alive on 11/19/23, 19...,

and that death occurred, on the date stated above, at 12:20 Am.

The CAUSE OF DEATH* was as follows:

Cancer of bowel with complications obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/13/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Roy M. Poloyt., M. D.

, 19 (Address) Church Home & Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Laurel Hill Phila Pa — DATE OF BURIAL: Nov 20 1923

20 UNDERTAKER: Chas D Mitchell — ADDRESS: 1201 N. Fayette St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80972

CERTIFICATE OF DEATH.

D 80972

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2802 Ulman Ave St. 5 WARD)

2-FULL NAME Hannah Louenthal

(a) RESIDENCE No. 2802 Ulman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan Louenthal

6 DATE OF BIRTH (month, day, and year): Jany 1st 1868

7 AGE — Years: 55 Months: 10 Days: 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. Gilbert Louenthal

(Address) 2802 Ulman Ave

15 NOV 19 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/19/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 10 1923 to November 19 1923.

that I last saw her alive on November 18. 1923.

and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma right breast.

(duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. M. Harrison M. D.

11/19. 1923 (Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 11/29/ 1923

20 UNDERTAKER: David Sandheim

ADDRESS: 118 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

D80973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 80973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 E. 25. ST., 17 WARD)

2-FULL NAME Elizabeth Davey Cathcart

(a) RESIDENCE NO. 102 E. 25th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H. G. Cathcart

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 81 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Henrietta M. Davey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Nannie E. Cathcart

(Address) 102 E. 25 St

15 Filed NOV 20 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 1913 ..., to Nov. 18, 1923,

that I last saw her alive on November 18, 1923,

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. M. Gill M. D.

Nov 14 1923 (Address) 7435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: Nov 20 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 80974 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80974

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 25 WARD)

2-FULL NAME Mrs Hattie Groupe

(a) RESIDENCE NO. Relay, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvin Groupe

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE Years 6 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm Hull

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) .....

14 Informant Calvin Groupe (Address) Relay Md

15 Filed ..... 19 ..... Registrar

NOV 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 19, 1923, that I last saw her alive on Nov 19, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Peritonitis
Intestinal Perforation
Carcinoma - Transverse
Colon (duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) M. Alexander Morley, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friends Cem't — DATE OF BURIAL 11/22 1923

20 UNDERTAKER Wm J. Tilbrett — ADDRESS North Ave

Spec.—1-10-21—M.&T.—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80975

CERTIFICATE OF DEATH.

74-006 D 80975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 28 WARD)

2-FULL NAME Johana Foran

(a) RESIDENCE NO. Mt Hope Retreat ST. 28 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Port Deposit. Md -

PARENTS

10 NAME OF FATHER Michael Foran

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johana Dody.

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland.

14 Informant: Records of Mt Hope Retreat (Address) Mt Hope Md -

15 NOV 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 - , 1920, to Nov 19 , 1923, that I last saw her alive on Nov 18th , 1923, and that death occurred, on the date stated above, at abt 11 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Abt Dementia Paralytica (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Towson Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Nov 19th 1923 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 11/24/1923

20 UNDERTAKER: Chas S. Evans & Son — ADDRESS: 11 S Wm St Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80976

CERTIFICATE OF DEATH.

D 80976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Ething ST., 17 WARD)

2-FULL NAME Ida E. Colbert.

(a) RESIDENCE NO. 1128 Ething ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Colbert.

6 DATE OF BIRTH (month, day, and year) April 5th 1871.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer) Home duties

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Wm S. Jolley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Thomas Colbert

(Address) 1128 Ething St.

15 NOV 20 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4 1921 to 11-17 1923

that I last saw h alive on 11-16 1923

and that death occurred, on the date stated above, at 11-35A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) 1 yr. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov-4-21.

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) S. Duncan M. D.

1923 (Address) 1504 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Nov 20 23

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80977.

D 80977.

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 N Calvert ST. 17 WARD)

2-FULL NAME Thomas H Plummer

(a) RESIDENCE NO. 1718 N Calvert St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. — How long in U. S., if of foreign birth? — — — yrs. — — — mos. — — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Glanding

6 DATE OF BIRTH (month, day, and year) Mch 19, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	8	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Maryland

PARENTS

10 NAME OF FATHER Eli Plummer

11 BIRTHPLACE OF FATHER (city or town) Kent Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary King

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Robert Ellis
(Address) 1718 N. Calvert St

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to Nov. 19, 1923, that I last saw him alive on Nov. 18, 1923 and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2+ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Those of Nephritis

(Signed) Walter C Bacon M. D.

11/19, 1923 (Address) 100 E 20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centerville Maryland	Nov 21 1923

20 UNDERTAKER H. W. Mears & Son ADDRESS 805 N Calvert St
Via Penn, R.R. Escort Mrs Robt. Ellis

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80978

CERTIFICATE OF DEATH.

44 D 80978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Juress

(a) RESIDENCE NO. 523 Luzerne Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Juress

6 DATE OF BIRTH (month, day, and year): June 29-1850

7 AGE: Years 73 | Months 4 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar-maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Caroline Juress

(Address) 523 N. Luzerne Ave.

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1923, to Nov. 16, 1923,

that I last saw him alive on Nov 16, 1923,

and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal obstruction - Carcinoma

Myeloma - metastases (duration) yrs. mos. ds.

Where was disease contracted if not at place of death? 523 N. Luzerne Ave

Did an operation precede death? Yes Date of Nov. 13, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem.

DATE OF BURIAL: Nov. 20 1923

20 UNDERTAKER: L. Sander Sons

ADDRESS: 1710 Park Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80979

CERTIFICATE OF DEATH.

90 D 80979

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Rosedale St. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Turnbull

(a) RESIDENCE No. 2102 Rosedale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Turnbull

6 DATE OF BIRTH (month, day, and year) Oct, 13, 1838

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Dolly Turnbull

(Address) 2102 Rosedale St.

15 Filed NOV 20 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1925 to Nov 14, 1923.

that I last saw h[illegible] alive on Nov 14, 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Heart disease Mitral Reg. and Chronic Bright disease

(duration) 15 yrs. — mos ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. R. Davis, M. D.

, 19 (Address) 1509 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Nov. 21, 1923

20 UNDERTAKER: Wm. C. Black, ADDRESS: 927 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D 80980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 80980

54

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Halted. Respess ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1905 Kennedy Ave

(a) RESIDENCE NO. Balt. Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a ~~Married~~, widowed, ~~or divorced~~

~~(or Wife)~~ HUSBAND of Matilda E. Respess

6 DATE OF BIRTH (month, day, and year) June 27, 1872

7 AGE: Years 50 yrs. Months 4 Days 23 If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Richard Respess

(Address): 1905 Kennedy Ave.

15 Filed NOV 20 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19- 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Nov 19, 1923.

that I last saw h[illegible] alive on Nov 19, 1923

and that death occurred, on the date stated above, at 10.20 Am.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) 7 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Post mort. No organs removed

What test confirmed diagnosis? Normal autopsy findings

(Signed) H. H. Harper M. D.

Nov 19, 1923 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Nov 21, 1923

20 UNDERTAKER: Mrs. Mrs John W. Teufel & Son

ADDRESS: 80 W. Fayette

Spec. 1-10-21 M&T 1500 Bks.

D 80981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80981

CERTIFICATE OF DEATH.

129 V

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 892 W. Balto. St. ST., 18 WARD)

2-FULL NAME Margaret S. Denoe

(a) RESIDENCE NO. 892 W. Baltimore St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	WIDOW

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 1868 June 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Richard Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Annie V Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Rachel Waters Denoe

(Address) 27 Bloomsbury Ave. Catonsville

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8 1923, to Nov 17 1923,

that I last saw h[illegible] alive on 1923,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw W Coolahan, M. D.

11/16 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEM.

DATE OF BURIAL 11/21 1923

20 UNDERTAKER ROBERT BROOKS 2D SON

ADDRESS COR CALHOUN HOLLINS ST

Spec.—1-10-21—M&T—1500 Bks.

D 80982 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 38 D 80982

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Andrew J. Miller

(a) RESIDENCE NO. Laurel Prince George Co., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Self. 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): U. S.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Hospital Records.

(Address)

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 20, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1923. to Nov. 20, 1923.

that I last saw him alive on Nov. 20, 1923.

and that death occurred, on the date stated above, at 1 20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Syphilis

(duration) Unknown yrs. mos.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema,

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy Hill Md. DATE OF BURIAL: Nov 22 19 23

20 UNDERTAKER: Jos E. French ADDRESS: Laurel Md

Spec.—1-10-21—M&T—1500 Bks.

D 30983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 30983

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 E Fayette ST. 6 WARD)

2-FULL NAME Harriet A. Sanders

(a) RESIDENCE NO. 1936 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 13-1847

7 AGE: Years 76 Months 4 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ~~[illegible]~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Samuel Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Lucinda Dreibelbis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Frances J. Barnes (Address) 1936 E. Chase

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1923, to 11-20, 1923, that I last saw her alive on 11-19, 1923, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~~unknown~~

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Rinehart, M. D.

11-20-23, 1923 (Address) 800 N. Mitchell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Nov 22 1923.

20 UNDERTAKER: Jno. C. Miller ADDRESS: 2834 Hoffman St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80984

CERTIFICATE OF DEATH.

161 D 80984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 283 S. Robinson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Michael Getner

(a) RESIDENCE NO. 283 S. Robinson ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19-1923

7 AGE — Years — Months — Days — If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Walter Getner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Bernetta Glass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Walter Getner

(Address) 283 S. Robinson

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar

NOV 20 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 19, 1923, that I last saw him alive on Nov 19, 1923 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Premature 7 month Foetus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) O. T. B. Tudor, M. D.

11/20, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Nov. 19 1923

20 UNDERTAKER: Wm. Sebastian Miller — ADDRESS: 2334 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

80985 HEALTH DEPARTMENT—CITY OF BALTIMORE D 80985

CERTIFICATE OF DEATH. 112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 W. Cross ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robert Schwartz

(a) RESIDENCE NO. 729 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 16 1923

7 AGE — Years: — Months: 1 — Days: 3 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Leslie Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hancock Md

14 Informant (Address): Norma Schwartz 729 W. Cross St

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1923. to Nov 19 1923;

that I last saw him alive on " " 1923,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pylonic Stenosis

(duration) yrs. 1 mos 13 ds.

CONTRIBUTORY (Secondary): Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw J Coulahan M. D.

11/20 1923 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov 20 1923

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1611 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80986

101-001

D 80986

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD) 21

2-FULL NAME Charles P. Gumpman

(a) RESIDENCE No. 714 St. Peter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Gumpman

6 DATE OF BIRTH (month, day, and year) June 12-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain Operator 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett + Hayward

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Minnie Gumpman

(Address) 714 St. Peter St.

15 Filed NOV 20 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th, 1923, to Nov. 18th, 1923, that I last saw him alive on Nov. 18th, 1923, and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 714 St. Peter St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) Wade E Hampson, M. D.

, 19 (Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov 21 1923,

20 UNDERTAKER James Tignan + Son — ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 80987.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 80987.

CERTIFICATE OF DEATH

161-001

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 839 N. Fremont Ave. St.; 17 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Baby Hubbard.

(Residence in Baltimore: No. 839 N. Fremont Ave. St.; ..... yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: November 19, 1923 (Month) (Day) (Year)

7 AGE: 0 yrs. 0 mos. 0 ds. If LESS than 1 day 20 hrs. or 0 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: ——
(b) General nature of industry, business, or establishment in which employed (or employer): ——

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William T. Hubbard Jr

11 BIRTHPLACE OF FATHER (State or country): Cambridge Md.

12 MAIDEN NAME OF MOTHER: Hazel K. Richardson

13 BIRTHPLACE OF MOTHER (State or country): Cambridge Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. T. Hubbard Jr

(Address) 839 N. Fremont Ave

15 NOV 20 1923

16 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 19, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923 to Nov 19 1923

that I saw him alive on Nov. 19, 1923

and that death occurred, on the date stated above, at 10.45 P.m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(6 mo. Foetus)

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Stansbury M. D.

Nov 20, 1923 (Address) 1037 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet — DATE OF BURIAL: Nov 20, 1923

20 UNDERTAKER: Josiah Taylor — ADDRESS: 1600 W North Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80988

D 80988

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 Whitehurst Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Appelbaum

(a) Residence No. 2314 Whitehurst Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rosa Appelbaum

6-DATE OF BIRTH (month, day and year)

7-AGE. 67 yrs. 6 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E Baltimore St

15- Filed NOV 20 1923 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/19/23

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1923 to Nov 19, 1923 that I last saw h. in alive on Nov 18, 1923 and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Decubitus Ulcers

(Duration) 5 yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Cerebrovascular Hypertension

(Duration) ... yrs. 2 mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph J Durkin M. D.

, 19 (Address) 1321 Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale — DATE OF BURIAL. 11/20 1923

20-UNDERTAKER. Jack Levis — ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80989

CERTIFICATE OF DEATH.

74-001 D 80989

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Madison Ave., ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Marowitz

(a) RESIDENCE No. 1801 Madison Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Leon Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin (Address) 1439 Eutaw St

15 Filed NOV 20 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 19- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Nov. 20, 1923 (Address) 2102 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom Cem | DATE OF BURIAL 11/20 1923

20 UNDERTAKER Jack Levin 1439 Eutaw St | ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80990

CERTIFICATE OF DEATH.

101001

D 80990

REGISTERED NO. C.....

1-PLACE OF DEATH Eastern

CITY OF BALTIMORE: (No. 753 Aelund St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Brown

(Residence in Baltimore: No. 753 Aelund St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Single

6-DATE OF BIRTH, April 15, 1882
(Month) (Day) (Year)

7-AGE, 41 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elvira Adolf

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth Brown

(Address) 753 Aelund St

15-

Filed NOV 20 1923, 191.... ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1923, to Nov 17 1923

that I saw h— alive on Nov 17 1923

and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Mv. Pneumonia

(Duration) ....yrs. 1 mos. ....ds.

(Signed) W. H. Howard M. D.

Nov 20, 1923 (Address) 712 S. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov 21, 1923
20-UNDERTAKER	ADDRESS
Jno. Gill Hoffa	406 W. Conway St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 80991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 80991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Dover ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ross Ross.

(a) RESIDENCE NO. 317 Dover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24 1921

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Solomon Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Ross

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Annie Scott
(Address) 917 Dover St.

15 Filed NOV 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to Nov 19, 1923,

that I last saw him alive on Nov 15, 1923,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. D. Smith M. D.

Nov 19, 1923 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Auburn Cemetery DATE OF BURIAL Nov 21 1923

UNDERTAKER Chas Groff Hoffa ADDRESS 406 N Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 80992

31 D 80992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. T 511 N. Norris St ST., 19 WARD)

2-FULL NAME Charlette Edwards

(a) RESIDENCE NO. 511 N.Norris St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Edwards

6 DATE OF BIRTH (month, day, and year) June 20, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23.	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Flemming Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Landcaster Co. Va.

12 MAIDEN NAME OF MOTHER Rose Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Landcaster Co. Va.

14 Informant William Edwards

(Address) 511 N. Norris St.

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11 , 19 23. to Nov. 17th. 1923 .

that I last saw h er alive on Nov. 17th. 1923 ,

and that death occurred, on the date stated above, at 8.30p. m.

The CAUSE OF DEATH* was as follows:

Acct. Exacebation of Ch. Parenchamatous Nephritis

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Ch. Paren. Nephritis

(duration) 1 yrs. 3e mos. ds.

18 Where was disease contracted If not at place of death? At place of de death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Chemical and Michrop ical Exam.

(Signed) Walter J. Jackson , M. D.

, 19 (Address) 1618 W. Mulberry st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Nov. 20, 1923.

20 UNDERTAKER Mrs Katie R. Williams — ADDRESS 322 W Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Examination of this patients chest showed signs strongly suggestive of pulmonary T.B.C. However X. Ray interpatations of Dr. Ashby did not agree with such.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80993 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 80993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 W Lexington St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Schnaffinger

(a) RESIDENCE NO. 946 W Lexington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 1865

7 AGE: Years 58 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Stove

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Schnaffinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J Keely

(Address) 946 W. Lexington St.

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 19 22 to Nov 18 19 23,

that I last saw h alive on Nov 18 19 23,

and that death occurred, on the date stated above, at 2-45 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Hommel, M. D.

1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL 11-21- 1923

20 UNDERTAKER H. Brauning Son

ADDRESS 517 S. Schroeder St

Spec. 1-10-21 M&T 1500 Blks.

D 80994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 80994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1161 Washington Blvd ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Burton

(a) RESIDENCE NO. 1161 West Bro St., WARD

(Usual place of abode) Att

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs Laura Burton

6 DATE OF BIRTH (month, day, and year) Apr 3 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
48	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) Sub Contractor

(c) Name of employer C. F. Lee.

9 BIRTHPLACE (city or town) (State or country) Frostburg Maryland

PARENTS

10 NAME OF FATHER Millard Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frostburg Md

12 MAIDEN NAME OF MOTHER M Holsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frostburg Md

14 Informant Mrs Laura Burton

(Address) 1161 Washington Blvd

15 Filed NOV 20 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-18-23, 19 ... to 11/19/23, 19 23, that I last saw h... alive on 11/19/23, 19 ..., and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mitchell Dorsey, M. D.

, 19 (Address) 1161 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL 11/21/23 19

20 UNDERTAKER Bernard A Funk — ADDRESS 1158 Washington Blvd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80995

CERTIFICATE OF DEATH.

100-001 D 80995

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1321 Holbrook St. ST., 9 WARD)

2-FULL NAME Dolores T. McNulty

(a) RESIDENCE No 1321 Holbrook St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 12/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jos. L. McNulty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Christine Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Jos. L. McNulty
(Address) 1321 Holbrook St.

15 Filed NOV 20 1923
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Owens, M. D.
(Coroner.)

Nov 20 1923 (Address) 50 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemy Hartford Rd DATE OF BURIAL Nov. 20 1923

20 UNDERTAKER Henry Stockell Son ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

5 yrs 8 mos in Mt Hope

D 80996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80996

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie B. Riley

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 25 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jno Riley

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Nolan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

Filed NOV 20 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18. 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 18. 1915, to Nov. 18 1923,

that I last saw her alive on Nov 17. 1923,

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with Paraplegia - (duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) Anuria Direct Childbood (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery M. D.

19 (Address) Mt Hope Retreat Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov 21 1923

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North Ave

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 80997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80997

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Masson

(a) RESIDENCE No. 313 S. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Edward Masson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montreal, Canada

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Municipal Hospital Records. (Address)

15 Filed NOV 20 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1923

17

I HEREBY CERTIFY, That I attended deceased from November 2, 19 23. to November 18, 19 23.

that I last saw h im alive on November 18, 19 23,

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis,
Syphilitic Aortitis
Aortic Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude G. Dent, M. D.

11-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 22 19

20 UNDERTAKER Robert P. Harrison

ADDRESS 1515 McCulloh St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80998 ✓ 90 D 80998

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 Bernard ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Thomas Marsh

(a) RESIDENCE. NO. 2729 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced ~~WIFE of~~ HUSBAND of Amanda Marsh

6 DATE OF BIRTH (month, day, and year) Oct. 31. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer Kimble + Tyler

9 BIRTHPLACE (city or town) (State or country) Balto Co- Md

PARENTS

10 NAME OF FATHER John Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fred Marsh

(Address) 2729 Bernard St

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923, to Nov 19, 1923, that I last saw h[illegible] alive on Nov 19, 1923, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular Renal disease (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) J. W. Chesnut, M. D.

11/19 1923 (Address) Towson, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laterr Balto Co	Nov 21 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

NOV 20 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 80999

CERTIFICATE OF DEATH.

100-001

D 80999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Preston Place WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie E Schaefer

(a) RESIDENCE. No. 2235 Preston Place WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Schaefer

6 DATE OF BIRTH (month, day, and year) Sept 22 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James H Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary A. Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles H Schaefer
(Address) 2235 Preston Place

15 Filed NOV 20 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 17th 23, to Nov 19th 23,
that I last saw h alive on Nov 17th 23,
and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 22 1923

20 UNDERTAKER CHENOWETH & SON.

ADDRESS 3617 CHESTNUT AVE.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81000

CERTIFICATE OF DEATH.

15 129

D 81000

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W Lexington St. Vol Amer Hosp WARD)

2-FULL NAME Carl Lisack

(a) RESIDENCE. No. 2805 Walbrook ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler at B & O R.R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Lisack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed NOV 20 1923 . 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17

I HEREBY CERTIFY, That I attended deceased from November 15 1923, to November 20, 1923

that I last saw h. alive on November 20, 1923,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo E. Wells, M. D.

. 19 (Address) 1521 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frdrksbrg Md	Nov 20 '23
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 20 1923

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81001 D 81001

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 Westwood ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agness Reardon

(Residence in Baltimore: No. 2417 Westwood ave St.; 4 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 15, 1893
(Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Mass

PARENTS.

10-NAME OF FATHER, W Bradley

11-BIRTHPLACE OF FATHER (State or Country). Mass

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Reardon

(Address) 2417 Westwood ave

15-

Filed ....., 191.. Robert P. Harrison, Registrar.

NOV 20 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1923, to Nov 16 1923, that I saw her alive on Nov 15 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. F. Wyatt M. D.

11-20, 1923 (Address) 35 E Montgomery St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem

DATE OF BURIAL, Nov 21, 1923

20-UNDERTAKER Robert Brooks & Son

ADDRESS Cor Calhoun Hollins Sts

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81002

CERTIFICATE OF DEATH.

101-06 ✓ D 81002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 S. Charles ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Brell

(a) RESIDENCE. No. 2020 S Charles ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Brell

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Grammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Christopher Fisher (Son) 2020 S. Charles St.

15 Filed 19 Robert P. Harrison, Registrar

NOV 20 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 1923, to Nov. 18, 1923, that I last saw her alive on Nov 18, 1923 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick, M. D.

, 19 (Address) 412 N. Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Nov. 22 1923
20 UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Light

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81003

90 D 81003

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Pennington Ave ST., 25 WARD)

2-FULL NAME Elizabeth Meyer

(a) RESIDENCE NO. 930 Pennington Ave ST., " WARD Baltimore Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Meyers

6 DATE OF BIRTH (month, day, and year) April 4 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbus O.

PARENTS

10 NAME OF FATHER H. Swainsberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elz. Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Mewshaw

(Address) 1016 Pennington Ave

15 Filed ..... 19..... Registrar

Robert F. Morrison,
Burial Permit Clerk.

NOV 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923, to Nov. 18, 1923, that I last saw h[illegible] alive on Nov. 17, 1923, and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

11/16/1923 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL Nov. 21 1923

20 UNDERTAKER Margaret E. Flynn ADDRESS 1422 Light St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81004

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore Station St., 25 Ward)

in city New York Blvd.

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. P. Davis

(Residence in Baltimore: No. West Baltimore Station St.; 72 yrs., ... mos. ..... ds.)

B & O. near Washington Park

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. Unknown 1850
(Month) (Day) (Year)

7-AGE. 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R.

9-BIRTHPLACE, (State or Country). Maryland

PARENTS:

10-NAME OF FATHER. Wm B. P. Davis

11-BIRTHPLACE OF FATHER. (State or Country) Federal, Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr George Davis

(Address) West Balto Station

15-

Filed NOV 20 1923, 192.

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

..... 192 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Nov 23 '23 192
20-UNDERTAKER. Wm J. Cowan & Son	ADDRESS 901 Fallsway

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 81005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81005

CERTIFICATE OF DEATH.

10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Curley ST., 6 WARD)

2-FULL NAME Charles C. Miller

(a) RESIDENCE No. 405 N Curley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	6		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Chas. Miller

(Address) 405 N. Curley St.

15 Robert P. Harrison, Registrar

19 Burial Permit Clerk.

NOV 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov. 20, 1923.

that I last saw him alive on Nov 19, 1923

and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria "Nasal & Pharyngeal"

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Cardiac Block

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Geo. Heller, M. D.

11/20, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/24/1923

20 UNDERTAKER E. J. Fanning & Son - 1460

ADDRESS Battery Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81006

CERTIFICATE OF DEATH.

159-002

D 81006

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1140 Battery Ave ST. 24 WARD)

2-FULL NAME Bernard H Thuman.

(a) RESIDENCE NO. 1140 Battery Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Nov 15 1923

7 AGE: Years ..... Months ..... Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Bernard H Thuman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Helena Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Bernard H Thuman (Address) 1140 Battery Ave

15 Filed NOV 20 1923, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923, to Nov 20, 1923.

that I last saw h[illegible] alive on Nov 20, 1923.

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

(Morbus Cardiacus
Morbus Caeruleus)

..... (duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C Mitchell M. D.

Nov 20, 1923 (Address) 1799 Williams Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C & Co — DATE OF BURIAL: 11-20 1923

20 UNDERTAKER: E & J B Hade — ADDRESS: 115 E Wash

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81007.

CERTIFICATE OF DEATH.

179 D 81007.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 25 WARD)

2-FULL NAME Lawrence F. Schwabland.

(a) RESIDENCE NO 119 N. First St. Brooklyn. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) March 5, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	14.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Schwabland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Bertha Weakland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Bertha Schwabland. (mother)
(Address) 119 N. First St Brooklyn.

15 NOV 20 1923

Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19th, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the face and body. Playing with Matches. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov, 19, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Accident 119 N. First St. Brooklyn. Nov. 19, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 11-21 1923

20 UNDERTAKER Earle Funeral — ADDRESS 115 E West St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81008

101-001 ✓ D 81008

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 E. Monument St ST., 5 WARD)

2-FULL NAME Elizabeth A. Smith

(a) RESIDENCE NO 1013 E. Monument St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Smith

6 DATE OF BIRTH (month, day, and year) June 5/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Factory Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER John Walsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Mary McMikek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Mrs Charles Brady
(Address) 6 N. Front St.

15 Filed NOV 20 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (Lobar)

..... (duration) ..... yrs. ..... mos 5 or 6 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cotter, M. D.
(Coroner.)

Nov 20/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL Nov. 21 1923

20 UNDERTAKER William G. Schaeffer — ADDRESS 1816 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81009

CERTIFICATE OF DEATH.

100-001

D 81009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W. Dell ST. 22 WARD)

2-FULL NAME Nancy E. Lee

(a) RESIDENCE NO. 105 W. Dell ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Willie Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Dyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Willie Lee

(Address) 105 W. Dell Street.

15 NOV 21 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/1923

17 I HEREBY CERTIFY, That I attended deceased from 11/15, 1923, to 11/18/1923, that I last saw her alive on 11/18/1923, and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

about (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

about (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Lumpkin, M. D.

11/19/1923 (Address) 908 Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL Nov 21 1923

20 UNDERTAKER John H. Toadvine

ADDRESS 1142 W. Lee St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81010

CERTIFICATE OF DEATH.

117

D 81010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 16 WARD)

2-FULL NAME Henry Maisch

(a) RESIDENCE NO. Sippel & Customs Co Respsburg, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Maisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Gertrude Thalheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Mrs Maisch

(Address) Respsburg

NOV 21 1923

ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1923, to Nov. 19, 1923, that I last saw h alive on Nov. 19, 1923, and that death occurred, on the date stated above, at 10.40 m.

The CAUSE OF DEATH* was as follows:

Perforated appendix, Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Sinus thrombosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Respsburg Md

Did an operation precede death? Yes Date of Nov. 14, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 22 1923
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81011

CERTIFICATE OF DEATH.

D 81011

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 E. Cross St. ST., 23 WARD)

2-FULL NAME Frank Cursey.

(a) RESIDENCE No 36 E. Cross St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Do not know. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report.
(Address) Southern District.

15 NOV 21 1923 ROBERT B. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Nov. 19, 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery — DATE OF BURIAL 11/21 1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81012

CERTIFICATE OF DEATH.

1294 D 81012

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Warren ST., 22 WARD)

2-FULL NAME Thomas Dowd

(a) RESIDENCE NO. 118 Warren ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Dowd

6 DATE OF BIRTH (month, day, and year): Nov 15 1863

7 AGE: Years 60 Months — Days 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. City

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Peter Dowd.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Riggin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Mary Dowd. 118 Warren st.

15 NOV 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30th, 1923, to Nov 20th, 1923, that I last saw him alive on Nov 30th, 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) ℓ

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ℓ

Did an operation precede death? No Date of ℓ

Was there an autopsy? No

What test confirmed diagnosis: Chem + Microsc.

(Signed) Augustus Thorn, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery. DATE OF BURIAL: Nov 23 1923

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Hayward Ave.

Cor.—1-12-23—M&T—100 Bks.

D 81013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81013

CERTIFICATE OF DEATH.

94-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1952 Walbrook Av. ST. 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. E. Kircher

(a) RESIDENCE NO. 1952 Walbrook Av. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Kircher

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collection Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Furniture
(c) Name of employer Gusdorf & Froelich

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Kircher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Neuhauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Neuhauser

14 Informant Mrs. Mary L. Kircher

(Address) 1952 Walbrook Av.

NOV 21 1923

Filed ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. T. Neumann M. D.
(Coroner.)

Nov. 19, 1923 (Address) 1802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesley Chapel, Rock Hall Md

DATE OF BURIAL Nov 22 1923

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Av

Spec. 1-10-21 M&T 4500 Blks.

D 81014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81014

45

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 18 WARD)

2-FULL NAME Solomon Thompson

(a) RESIDENCE NO. 818 West Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Moses Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant University Hosp. Records
(Address)

NOV 21 1923

H.A.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1923, to Nov. 20, 1923,

that I last saw him alive on Nov 20, 1923,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon with metastases to Liver

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Nov. 19, 1923

Was there an autopsy?

What test confirmed diagnosis? Clinical + Laboratory Findings

(Signed) Dorrd R. Newcomer, M. D.

Nov 20, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Co. Lot 2 Sec 2 Woodland

DATE OF BURIAL Nov 24 1923

20 UNDERTAKER Brown Freeland & Schroder

ADDRESS 114 W Lexington St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81015

CERTIFICATE OF DEATH.

129 D 81015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5229 Reisterstown Road ST.) 27 (WARD)

2-FULL NAME James E. Watson

(a) RESIDENCE NO. 5229 Reisterstown Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret V Watson

6 DATE OF BIRTH (month, day, and year) Sept 25, 1842

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
81	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: R H Watson

(Address) 5229 Reisterstown Road

15 NOV 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-5-, 1923, to 11-19-, 1923,

that I last saw h~~im~~ alive on 11-19-, 1923,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis (Chronic)

— (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm G. Sawell M.D.

Nov 21 1923 (Address) 36-23 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Lorraine

DATE OF BURIAL Nov 23 1923

20 UNDERTAKER Geo W Little

ADDRESS 2708 EDMONDSON AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81016

CERTIFICATE OF DEATH.

D 81016

124

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2213 E. Baltimore St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Abramovitz

(a) Residence No. 2213 E. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant) Louis Abramovitz

(Address) 475 S. Pimlico Road

15- NOV 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-21-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Nov 20, 1923

that I last saw her alive on Nov 20, 1923

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C O Lloyd M. D.

, 19 (Address) 1913 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrin Rosedale

DATE OF BURIAL, 11/21, 1923

20-UNDERTAKER: Jack Lewis

ADDRESS 1409 Eutaw

Spec– 12-23-21–E.B.R.S.—400 Blks.

D 31017. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 31017

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2102 Callow Avenue St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Max Korb .....

(a) Residence No. 2102 Callow Avenue St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Korb

6-DATE OF BIRTH (month, day and year)

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS

10-NAME OF FATHER: Morris Fishel Korb

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ruuuia

12-MAIDEN NAME OF MOTHER: Gitel Stein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

11- (Informant): Rebecce Korb

(Address): 2103 Callow Ave.,

15- NOV 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11.20-23

17- I HEREBY CERTIFY, That I attended deceased from November 18. 1923 to November 20. 1923 that I last saw h.im alive on November 20. 1923 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocardit.is - cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles T. Bussmann M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Cem

DATE OF BURIAL: 11/21 19 23

20-UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eutaw

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81018

CERTIFICATE OF DEATH.

90 D 81018

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Colonial Hospital ST., 1 WARD)

2-FULL NAME .. Rubin Sylvester

(a) RESIDENCE NO 2521 Eutaw Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) About 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 75 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) Soldier
(c) Name of employer U. S. A.

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant W. M. Routson
(Address) 2238 N. Monroe

15 NOV 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.
Filed 192

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute oedema of lungs.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

(duration) yrs. mos. 3 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 19, 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park M E Sect	Nov 22 1923
20 UNDERTAKER	ADDRESS
H M Routson	2238 N Monroe

Fill out all items, if possible. See instructions on back of certificate.

Spec. 1-10-21 M

81019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81019

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 Linden Ave ST., 13 WARD)

2-FULL NAME Carrie Summerfield

(a) RESIDENCE NO. 2205 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Summerfield

6 DATE OF BIRTH (month, day, and year) Aug 5 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73		2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Nathan Schwartzbauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cecelia Applebaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Artz Summerfield (Address) 2205 Linden Ave

Filed NOV 21 1923 ROBERT R. KRETSCH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923, to Nov 20, 1923, that I last saw h[illegible] alive on Nov 20, 1923, and that death occurred, on the date stated above, at 7 40 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; angina pectoris; myocarditis

Duration 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis P Hamburger, M. D.

11/20, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 11/22/ 1923

20 UNDERTAKER David Sondheim — ADDRESS 115 W. Mt. Royal Ave

(See note attached)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81020

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 81020

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Division ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Reynolds (Ridgeley)

(a) RESIDENCE. NO 1708 Division ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower:

6 DATE OF BIRTH (month, day, and year) Feb 2 - 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter in Store

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery establishment

(c) Name of employer Landsing machinery Corp't Co.

9 BIRTHPLACE (city or town) (State or country) Balto County, Md.

PARENTS

10 NAME OF FATHER George Ridgeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Priscilla Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cow Arundel Co Md.

14 Informant (Address) Elias H Kite. Towson Co Baltimore Co. Md

15 Filed NOV 21 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Nov 20, 1923, that I last saw h— alive on Nov 19, 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis and Suspected carcinoma of duodenum (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

11/21/1923 (Signed) Bernard J Freund, M. D.

(Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	Nov 23 1923
20 UNDERTAKER John H Owens	ADDRESS 538 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irres-

PHONE, GILMOR 402

DR. B. S. FRENCH
1707 EDMONDSON AVENUE

NOV 23 1938

ADDRESS .....

REG. No 3564

DATE 11-23-38

PATIENT'S NAME .....

℞ This to certify that,
the name given
is correct. and
name of the
attending physician
errors.

LEMLER'S DRUG STORE
PHONE, GILMOR 3888
FRANKLIN AND MOUNT STREETS
BALTIMORE, MD.

...malignancy), *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease ... *death*), *29 ds.; Bronchopneumonia* (second- ... *ds.* Never report mere symptoms or terminal ...ns, such as "Asthenia," "Anemia" (merely ...natic). "Atrophy," "Collapse," "Coma,""Con- ...," "Debility" ("Congenital," "Senile," etc.), ...," "Exhaustion," "Heart failure," "Hemor- ..."Inanition,""Marasmus,""Old age,""Shock," ...," "Weakness," etc., when a definite disease ...scertained as the cause. Always qualify all ... resulting from childbirth or miscarriage, as ...RAL *septicemia*," "PUERPERAL *peritonitis*," ...te cause for which surgical operation was ...ken. For VIOLENT DEATHS state MEANS OF ... and qualify as ACCIDENTAL, SUICIDAL, or ...AL, or as *probably* such, if impossible to ...e definitely. Examples: *Accidental drown- ...ruck by railway train—accident; Revolver ...f head—homicide; Poisoned by carbolic acid ...bly suicide.* The nature of the injury, as ... of skull, and consequences (e. g., *sepsis*, ... may be stated under the head of "contribu- ...(Recommendations on statement of cause of ...pproved by Committee on Nomenclature of ...rican Medical Association.)

...TIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81021

CERTIFICATE OF DEATH.

D 81021

49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Symon Buzgirski

(a) RESIDENCE NO. 2219 Winterling Court ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER August Puzesski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 NOV 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 13 1923 to November 20 1923.

that I last saw him alive on November 19, 1923,

and that death occurred, on the date stated above, at 1:10 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Testicle

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Wilcox, M. D.

11-22-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Bem.

DATE OF BURIAL Nov. 23. 1923.

20 UNDERTAKER M. F. Sadowski,

ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81022

111-002

CERTIFICATE OF DEATH.

D 81022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: NO. 1112 N. Mount ST. 16 WARD)

2-FULL NAME Mrs. Leah Allstatter Schnitzer

(a) RESIDENCE NO. 1949 Harlem ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1865, April 18-

7 AGE Years 58 Months 7 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Allstatter Pa
(State or country)

PARENTS

10 NAME OF FATHER John Barnes

11 BIRTHPLACE OF FATHER (city or town) Hollstrugh, Pa
(State or country)

12 MAIDEN NAME OF MOTHER Leah Megg Evans

13 BIRTHPLACE OF MOTHER (city or town) Wales
(State or country)

14 Informant Rolf W. Schnitzer son
(Address) 1949 Harlem Ave

15 Filed NOV 21 1923 . 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/11/ . 19 23 to 11/20/ . 1923.

that I last saw her alive on Nov. 20 . 1923.

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/12/23

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. A. Swagman, M. D.
Resident

. 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Getterburgh Pa — DATE OF BURIAL Nov 23 1923

20 UNDERTAKER Jos Joerdens Son — ADDRESS 2178 Pen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81023

CERTIFICATE OF DEATH.

D 81023

113

1-PLACE OF DEATH CITY OF BALTIMORE (No. 1611 Pennington Av. ST., 25 WARD) Brooklyn

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo R. Ferrell

(a) RESIDENCE No. 1611 Pennington Ave ST., Brooklyn WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	0	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter Ferrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mollie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Ferrell

(Address) 1611 Pennington Ave Brooklyn

15 Filed NOV 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923 to Nov 19, 1923

that I last saw h— alive on Nov 19, 1923

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon J Horich, M. D.

, 19 (Address) Curtis Bay Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 11 22 1923

20 UNDERTAKER E O B Hahn — ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 81024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 D 81024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 E Fort ave ST., 24 WARD)

2-FULL NAME Louis D Halfpenny

(a) RESIDENCE No. 1230 E Fort ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1916

7 AGE Years 7 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Robt J Halfpenny

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa E Doyle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Louisa E Halfpenny (Address) 1230 E Fort ave

15 Filed NOV 21 1923 ROBERT R. KRAUTER, Assistant, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 19 23

17 I HEREBY CERTIFY, That I attended deceased from 11-18 1923 to 11/20 1923

that I last saw him alive on 11/20 1923

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(Toxic Cause mushroom)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown 3, M. D.

19 , 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Inc — DATE OF BURIAL Nov 23 23

20 UNDERTAKER Robt Johnson Sr — ADDRESS 1st Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVATION OF RIGHTS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 81025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1019 N 37 St. | 15 WARD)

REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan B. Frock

(Residence in Baltimore: No. 1019 N 37 St.; yrs., 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec (Month) 3 (Day) 1850 (Year)

7-AGE, 72 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... NO

9-BIRTHPLACE, (State or Country), Balto Co, Md

PARENTS.

10-NAME OF FATHER, Abraham Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md

12-MAIDEN NAME OF MOTHER Sarah J. Hatton

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Irving Riddle

(Address) 1019 N 37 St

15- Robert P. Harrison, ..., 191.....

Burial Permit Clerk Registrar.

OCT 21 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess
Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) [signature] M. D.

(Corner) (Address) 3532 Roland Ave

Oct 20, 1923.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Dales Church Balto Co	Oct 22, 1923
20-UNDERTAKER	ADDRESS
A S Marshall	353 Roland Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81026

D 81026 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3906 Phila. Ave ST. 26 WARD)

2-FULL NAME Harry Hutton Jr

(a) RESIDENCE NO. 3906 Phila Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 19 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Harry Hutton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Annie M. Greisel

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Harry Hutton

(Address) 3906 Phila Ave

NOV 21 1923 H. Lane
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 20, 1923, that I last saw h[e] alive on Nov 20, 1923, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth of 8 months pregnancy + Heart failure, Clinical

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Lockard, M. D.

11/21, 19 21 (Address) 1701 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem — DATE OF BURIAL Nov 21 1923

20 UNDERTAKER John McCrick — ADDRESS 208 Green

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 81027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81027

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 15 WARD)

2-FULL NAME Lydia Bazzardi.

(a) RESIDENCE No. 812 Ashburton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk. 009

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Thomas Hovey

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Eliz. King

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Record, (Address)

15 Filed NOV 21 1923 H. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/23 19

17 I HEREBY CERTIFY, That I attended deceased from 11/14/23, 19 ..., to 11/20/23, 19 ..., that I last saw h. alive on 11/20/23, 19 ..., and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure.

..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 22 1923

20 UNDERTAKER John Merrick

ADDRESS 2007 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

D 81028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81028

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Wm Craven

(Residence in Baltimore: No. Landover Md. St.; yrs.....mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Unknown ..... 1.....
(Month) (Day) (Year)

7-AGE
.....yrs.....mos.....ds. (About 60)

If LESS than 1 day,
....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Trade many
(b) General nature of industry, business, or establishment in which employed (or employer)..... Penna R.R.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Polen

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Frost

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Coroner Riley

(Address) 1639 Broadway

15-

Filed ..... 192.....

Registrar.

NOV 21 1923

Richard W. Barnhart
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23 ....., 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract spine Cause
by accidentally falling from
R.R. car
(Duration) 5 days mos. ds.

CONTRIBUTORY .....
(Secondary)
(Duration) .....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 24 1923. (Address) 1639 Broadway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 5 days In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Landover Md.	11-23-23
20-UNDERTAKER,	ADDRESS
Wm. J. Tichnor Sons	North Penna Ave

WRITE PLAINLY, WITH PENCIL OR INK. 18.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 81029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81029

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Elizabeths Home Chestnut Hill Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Albert Brown

(a) RESIDENCE. No. St. Elizabeths Home - Chestnut Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 19/1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None gpd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant (Address) Robert P. Harrison.

15 [illegible] . 19

NOV 21 1923

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19 1923

17 I HEREBY CERTIFY, That I attended deceased from November 15, 1923, to November 18, 1923, that I last saw h[illegible] alive on November 18, 1923, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE (IF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Probable Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Nov 19, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

NOV 20 1923

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81030

CERTIFICATE OF DEATH.

81030

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Boze Mitchell

(a) RESIDENCE NO. 1616 W. Mulberry ST ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Mitchell

6 DATE OF BIRTH (month, day, and year): Sept 15-1863

7 AGE — Years: 60 — Months: 2 — Days: 3 — If LESS than 1 day ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Records Johns Hopkins Hospital

15 Filed ..... 19 Robert P. Harrison, Registrar

Deputy Clerk.

NOV 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 9 - 1923 to Nov 18 1923.

that I last saw him alive on Nov 18 - 1923,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of the arch of the aorta

(duration) 1 yrs. 2 mos. - ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Alabama

Did an operation precede death? Yes Date of Nov 10, 1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) P B Mac Cready, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 20 1923

20 UNDERTAKER: Commissioner Health,

ADDRESS

For Wm R. WOODALL.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Cor.—1-12-23—M&T—100 Bks.

D 81031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81031

CERTIFICATE OF DEATH.

91-005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Wiest

(a) RESIDENCE NO Bolt Jail ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan Rice

6 DATE OF BIRTH (month, day, and year) Dan Rice

7 AGE Years Dan Rice Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robert P. Harrison (Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 192 Registrar Burial Permit Clerk.

NOV 21 1923

0889 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cute Arteriosclerosis

Dan Rice (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ils.

(Signed) W. J. Ruby, M. D.

Nov 18, 1923 (Address) (Coroner) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death yrs., mos., ds. In the State 2 mos. yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81032

CERTIFICATE OF DEATH.

D 81032

REGISTERED NO. 26 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD)

2-FULL NAME Major Jiggitts. (C).

(a) RESIDENCE NO. 1623 S. Clinton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Widower.

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~the wife of~~ Matilda Jiggitts. (C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevadore
(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake Lighterage & Towing Company.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Edmund Jiggitts. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Amamda ------. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Buck Jiggitts (C)(brother)
(Address) 1635 W. Lexington St.

15 [illegible] 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13th, 1928. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arterio sclerosis.
Cerebral hemorrhage.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov. 19, 1923 (Address) 1017 S. Charles St.

(C) State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Pier b. Locust Point. Nov, 9th, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 21 1923

[illegible] MORGUE. [illegible] Clerk.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81033

D 81033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S Exeter ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Masino

(a) RESIDENCE NO. 311 S Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Masino

6 DATE OF BIRTH (month, day, and year): Oct 10 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
64	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Antoney Spalafula

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: John Masino

(Address): 311 S Exeter

15 Filed ..., 19 Robert P. Harrison, Registrar

NOV 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sep 1, 1923, to Nov. 19, 1923,

that I last saw her alive on Nov. 18, 1923,

and that death occurred, on the date stated above, at 7:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Cassard M. D.

11.20.23, 19 (Address) 2m Hicks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Nov 21 1923

20 UNDERTAKER: Wendell Ryffel & Son

ADDRESS: 373 N

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81034

CERTIFICATE OF DEATH.

3 / D 81034

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Albemarle ST., 3 WARD)

REGISTERED NO. .....
(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Minoso

(a) RESIDENCE NO. 314 Albemarle ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		7	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Michael Minoso

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Alfonsa Innarosso

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Michael
(Address) 314 Albemarle

15 Filed Burial Permit Clerk
Registrar

NOV 21 1923

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 19, 1923, that I last saw him alive on Nov. 19, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. L. Cusano, M. D.
11-20-23 19 (Address) 2nd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	21 1923
20 UNDERTAKER	ADDRESS
Wendel Offel & Son	3782

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81035

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81035

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of Chas 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Kessinger

(a) Residence No. Preston & Caroline St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE~~ of John Kessinger

6-DATE OF BIRTH (month, day and year)

7-AGE, 71 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. 6

(b) General nature of industry, business, or establishment in which employed (or employer). 6

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS

10-NAME OF FATHER, John Dane

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country),

12-MAIDEN NAME OF MOTHER, Sarah —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

14- (Informant) Sister Florence

(Address) Preston & Caroline

15- Filed ..... 192..... Registrar.

NOV 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/19/23

17- I HEREBY CERTIFY, That I attended deceased from 11/10 1923 to 11/19 1923 that I last saw h[er] alive on 11/18 1923 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sisters of Temp

(Duration) ..... yrs. 8 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolf M. D

11/20, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Peters	11-22-1923
20-UNDERTAKER,	ADDRESS
J. C. Windfield	917 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16333 D 81036 — X 86 001 — D 81036

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Hopkins Hosp. 7

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Bernard Gamble

(a) RESIDENCE NO. Towson, Md. R. F. D. #6 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) June 5, 1923

7 AGE — Years: — Months: 5 Days: 15 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): H

(c) Name of employer: H

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Gamble

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillian Sappington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Record (Address) Johns Hopkins Hosp

15 Filed ..... 19 ..... Registrar

NOV 21 1923

(Before [illegible] Burial permit clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923 to Nov 19, 1923.

that I last saw him alive on Nov 19, 1923

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Otitis media, acute (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Casper Taussig ....., M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Immaculate Con. Towson — DATE OF BURIAL: Nov 22, 1923

20 UNDERTAKER: E. LeRoy Stifflen — ADDRESS: 125 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81037 ✓ D 81037

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3201 Eastern ave ST. (Ward) No

2-FULL NAME John Hofmeier

(a) RESIDENCE NO. 3201 Eastern ave ST. 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pet

6 DATE OF BIRTH (month, day, and year) ~~Nov~~ 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Groceryman 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Hofmeier

(Address) 3201 Eastern ave

15 Filed NOV 21 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 19 23, to Nov 19, 19 23,

that I last saw him alive on Nov 19, 19 23,

and that death occurred, on the date stated above, at 5.05 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Heart Murmur

(Signed) [illegible], M. D.

, 19 (Address) 3015 Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery DATE OF BURIAL Nov. 22 1923

20 UNDERTAKER Geo W. Fink & Son ADDRESS 811 N Wolfe

WARNING—THIS CERTIFICATE IS A PERMANENT RECORD. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81038

CERTIFICATE OF DEATH.

129 D 81038

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 Brehms Lane St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Martha Graban

(a) Residence No. 106 N 11th St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? 1884

7-AGE. 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Chicago

PARENTS.

10-NAME OF FATHER, Carl Graban

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Marie Kutscha

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mr. H. Graban

(Address) 106 N. 11th St

15- Filed Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 20-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1923 to Nov 20th 1923

that I last saw her alive on Nov 20th 1923

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Nervous Prostration + Bed sores

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem. DATE OF BURIAL, Nov 23 19 23

20-UNDERTAKER. Peter Nicolaus ADDRESS 2041 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81039

CERTIFICATE OF DEATH.

90 D 81039

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. High St., 3 WARD)

2-FULL NAME Rosa Bacigaloupa

(a) RESIDENCE NO. 408 S. High St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bacigaloupa

6 DATE OF BIRTH (month, day, and year): 9/20/1845

7 AGE: 78 Years — Months 28 Days — If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: John Bacigaloupa

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Caterina Bacigaloupa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Caterina Deute 408 S. High St.

15 ... 19 ... Registrar

NOV 2 T 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to March 18, 1923, that I last saw h— alive on March 18, 1923, and that death occurred, on the date stated above, at 9-40 a. m.

The CAUSE OF DEATH* was as follows:

Heart failure - due to senility of old age

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Matt L. Valentine M. D.

3/20, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 11/22/23

20 UNDERTAKER: Geo. J. Dutt

ADDRESS: 1735 Harford Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Valvular Lesions of Heart

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81040

CERTIFICATE OF DEATH.

119 D 81040

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 185 W Saratoga ST., 4 WARD)

2-FULL NAME Ella Diggs

(a) RESIDENCE NO. 185 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Diggs

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Charity Stuart

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Letha Ewe

(Address) 185 W Saratoga

15 NOV 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1923, to Nov 19, 1923, that I last saw h alive on Nov 19, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Rheumatism
Pleuri Resto Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Septic Infection

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F Howard, M. D.

Nov 22 1923 (Address) 4 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: Nov 22 1923

20 UNDERTAKER: Edward Bryan — ADDRESS: 1031 Arlington Ave

Cor.—1-12-23—M&T—100 Blks.

D 81041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81041

CERTIFICATE OF DEATH.

177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Swiczkowski

(a) RESIDENCE NO 1248 S. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 10/1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Floor-sweeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hotel Emerson

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Swiczowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Swiczowski (Bro)
(Address) 1248 S. Ellwood Ave.

NOV 22 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident
Mercurical Poisoning-Suicide
See Letter attached

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

Nov 21/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Findings of Coroner's Jury Dec 21-1923

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL Nov. 22 1923

20 UNDERTAKER Wendell Hoppe & Son

ADDRESS 37 Lloyd St

MAKE LEGIBLE, WITH CARBON PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

J. S. H. POTTER, M. D.
508 NORTH AVENUE, EAST
BALTIMORE, MD.

December 21, 1923.

Registrar of Vital Statistics,

Department of Public Safety,
311 Courtlandt Street,
Baltimore, Md.

D-81041

Dear Sir:- In the case of Vincent Swiszkowski, who died on Nov, 19/23 at Johns Hopkins Hospital, I made inquiry and upon information received, I issued a certificate of death on or about Nov. 21st. 1923 as follows:- Mercurial Poisoning- Suicide (Autopsy at Hopkins Hospital) which you will find on file at the Health Department.

On this day December 21st. 1923 at 8.30 P.M. an inquest was held at the Northeastern Police Station and a jury of twelve men, after being duly sworn by me and hearing the testimony, upon their oaths rendered the following verdict:-"That Vincent Swiszkowski came to his death on November 19/1923 at Johns Hopkins Hospital, cause of death, mercurial poisoning, said poison accidently self Administered."

Very Respectfully,

J. S. H. Potter M. D. Coroner,
Northeastern District.

D 81042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81042

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1813 Maryland Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Logan Robinson

(Residence in Baltimore: No. 1813 Maryland St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, Aug. 3 1848 (Month) (Day) (Year)

7-AGE, 75 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Cooper Smith Co

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Nelson Robinson

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Jane Hutchins

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. F. Warner

(Address) 1813 Maryland

NOV 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 1 mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Nov. 21, 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov. 22 1923
20-UNDERTAKER.	ADDRESS.
J. T. Hutchins	Bath

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81043 | CERTIFICATE OF DEATH. | 45 D 81043

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 416 Whitridge Av ST. 17 WARD)

2-FULL NAME Mary Elizabeth Gladmon

(a) RESIDENCE NO. 411 Whitridge Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Christopher Gladmon

6 DATE OF BIRTH (month, day, and year) Aug 17 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None 037
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Joseph Hagner
11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md
12 MAIDEN NAME OF MOTHER Anna Mack
13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Mrs C Gladmon
(Address) 411 Whitridge Av

15 Filed NOV 2 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 8 1923 to Nov 20 1923.
that I last saw her alive on Nov 20 1923,
and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:
Cancer of Rectum

(duration) 1 yrs. mos ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At her home
Did an operation precede death? Yes Date of Mch 10, 23
Was there an autopsy? No
What test confirmed diagnosis? Per operation
(Signed) E. H. Duncan M. D.
Nov 20 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Balto Co — DATE OF BURIAL: 11/22 1923

20 UNDERTAKER: W J Tedmon & Sons — ADDRESS: North & Pt Sts

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81044

CERTIFICATE OF DEATH.

161-001

D 81044

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1615 Lancaster ST., 7 WARD)

2-FULL NAME Wladislaus Wilczynski,

(a) RESIDENCE NO. 1615 Lancaster ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or 15 min.
0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work gvd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Wladislaus Wilczynski,

11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Wanda Koslowski,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant Wanda Wilczynski, (Mother)

(Address) 1615 Lancaster St

15 Filed NOV 22 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 st. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Nov 21, 1923, that I last saw h[illegible] alive on Nov 21, 1923 and that death occurred, on the date stated above, at 10 1 m.

The CAUSE OF DEATH* was as follows:

Stomach Pain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Ryan M. D.

Nov 22 1923 (Address) 801 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEMETERY

DATE OF BURIAL NOV. 22 1923/

20 UNDERTAKER M. J. Sadowski,

ADDRESS 705 S. Ann St

D 81045

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

D 81045

REGISTERED NO. C.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Stafford Hotel St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florida H. Carrington

(Residence in Baltimore: No. Stafford Hotel St.; Unknown yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Write the word): widow

6-DATE OF BIRTH: ..... (Month) ..... (Day) Unknown (Year)

7-AGE: 71 yrs. mos. ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (no)

9-BIRTHPLACE (State or country): Georgia.

PARENTS

10-NAME OF FATHER: Rosan Harrison

11-BIRTHPLACE OF FATHER (State or country): Georgia.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Campbell Carrington

(Address) 40 Exchange Place New York

15- Filed ..... 191.....

NOV 22 1923

ROBERT R. KRAUTER REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 20, 1923, to, November 20 1923, that I saw h.er alive on November 20 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs 1 mos. 20 ds.

Contributory (SECONDARY) Broncho pneumonia

(Duration) ..... yrs 0 mos. 1 ds.

(Signed), Henry T. Collenberg M. D.

Nov. 21, 1923. [Address] 904 N. Charles St.

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov. 22, 1923

20-UNDERTAKER: Wm. O. Hall

ADDRESS: 501 E. Monument

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81046

CERTIFICATE OF DEATH.

1001
100 D 81046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gershul Shomer

(a) RESIDENCE No. 2331 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Shomer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Presser (Clothing)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abe Shomer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sania Dinkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Baltimore St.,

15 Robert P. Harrison, Registrar

NOV 22 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 or 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patterson, M. D.
(Coroner.)

11/22/23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Rosedale	11/27/1923

20 UNDERTAKER Jack Levin ADDRESS 439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81047

CERTIFICATE OF DEATH.

90 ✓ D 81047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 E. Baltimore ST., 6 WARD)

2-FULL NAME Isreal Snyder

(a) RESIDENCE NO. 2014 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Snyder

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Getzel-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Millie Snyder
(Address) 2014 E. Baltimore St.

15 Robert P. Harrison, Registrar

NOV 22 1923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis-History of Insuffiency (duration) yrs. mos. ds.

(Signed) J S Pollen, M. D. (Coroner.)

11/22/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 11/23 192 3

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

INFORMATION, WHICH SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81048

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1353 Jackson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Scott

(a) Residence No. 1353 Jackson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feb 17-1861

7-AGE: 62 yrs. 9 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Scotland

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14- (Informant) Robert C. Scott

(Address) 1353 Jackson st

15- NOV 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 20/923

17- I HEREBY CERTIFY, That I attended deceased from Nov 13, 1923, to Nov 20, 1923, that I last saw him alive on Nov 20 1923, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. A. Smith M. D

Nov 21, 1923 (Address) 69 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Nov 23, 1923

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81049

CERTIFICATE OF DEATH.

161-081 ✓ D 81049

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Mehring

(a) RESIDENCE No. 313 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1923

7 AGE: 20 hours — Years — Months — Days — If LESS than 1 day, 20 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm. H. Mehring.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Rachael M. Wolfstal.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant (Address) Wm H Mehring 313 East North ave

15 NOV 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923, to Nov. 21, 1923, that I last saw her alive on Nov. 21, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

1 mo.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) G. Latrobe Ewalt, M. D.

11/21, 1923 (Address) 2945 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul's Pikesville Md — DATE OF BURIAL: 11/22/1923

20 UNDERTAKER: Geo. Weber & Son — ADDRESS: 2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81050

CERTIFICATE OF DEATH.

31 D 81050

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 219 Arlington Ave (St.) 18 (WARD)

2-FULL NAME Susie Broadus

(a) RESIDENCE No. 219 Arlington Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Daniel Broadus

6 DATE OF BIRTH (month, day, and year): — — 1895

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westmoreland Co Va

PARENTS

10 NAME OF FATHER: Robert Quarles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westmoreland Co Va

12 MAIDEN NAME OF MOTHER: Emma Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westmoreland Co Va

14 Informant (Address): Charles Quarles 1204 W Lexington St

15 Filed 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 21, 1923, that I last saw her alive on Nov 21, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. V. Lovell, M. D.

11/24, 1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leeds Town Va.

DATE OF BURIAL: 11-22 1923

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81051

CERTIFICATE OF DEATH.

X90 D 81051

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. N.W.Cor. Harford & Federal WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dallas M. Harrison

(a) RESIDENCE No Gwynn Oak Ave. Woodlawn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine (Davis) Harrison

6 DATE OF BIRTH (month, day, and year) Oct. 29/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard N. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northumberland Co. Va.

12 MAIDEN NAME OF MOTHER Mararet Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Annie A. Ford (Sister)
(Address) 41 E. Henrietta St.

15 NOV 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Chr. Myocarditis

(duration) yrs. mos. ds.

(Signed) J. S. W. Patterson M. D. (Coroner.)

Nov 21 23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 11/22/23 192

20 UNDERTAKER J J Fahey Sons

ADDRESS 1315 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

Ries

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81052

CERTIFICATE OF DEATH.

49 D 81052

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 E. Biddle St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ries

(a) Residence No. 1215 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Barbara Ries (nee Hess)

6-DATE OF BIRTH (month, day and year)

7-AGE, 66 yrs. 10 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Stone

(b) General nature of industry, business, or establishment in which employed (or employer). Super. 034

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Leonard Ries

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Andrew E. Ries

(Address) 1215 E. Biddle

15- Filed NOV 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 20 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 5, 1922, to Nov 20, 1923, that I last saw him alive on Nov 20, 1923, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 926 Orchard St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Clinical

(Signed) James M Hendon, M. D.

11/21, 1923 (Address) 706 E Lovegrove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 23. 1923

20-UNDERTAKER, Edward W. Conklin — ADDRESS 924 E. Eager

Spec.—1-10-21—MAT—1500 Bks.

D 81053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81053

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1617 Bolton ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Joseph Yoe

(a) RESIDENCE NO. 1617 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cassie Moylan

6 DATE OF BIRTH (month, day, and year) May 21, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	0	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Yoe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Blanche Yoe
(Address) 1617 Bolton St.

NOV 22 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923, to Nov 20, 1923, that I last saw him alive on Nov 20, 1923, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Lloyd M. D.

, 19 (Address) 22 32 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/23 19 23
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 81054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D 81054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. 20th St. Ward 12)

2-FULL NAME John Toal

(a) RESIDENCE. No. 413 E. 20th St., Ward.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Toal

6 DATE OF BIRTH (month, day, and year): June 19th 1839

7 AGE — Years: 84 — Months: 5 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Philip Toal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary T. Toal 413 E. 20th St.

15 Filed NOV 22 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923, to Nov 21, 1923, that I last saw h.. alive on Nov 21, 1923, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Old Age - Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry M. D.

, 19 (Address) 3414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Hartford Co. — DATE OF BURIAL: Nov 24 1923

20 UNDERTAKER: E. A. Windsheimer — ADDRESS: 501 E. 22 St.

NOV 22 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81055

CERTIFICATE OF DEATH.

Registered No. 1549

1-PLACE OF DEATH

City of BALTIMORE: (No. 938 Washington Blvd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M. Schneider

(a) Residence No. 938 Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

M-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 9-1923

7-AGE. yrs. mos. 13 ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Charles Schneider

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Annie F. Earehart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Altoona Pa

11- (Informant) Chas Schneider

(Address) 938 Wash. Blvd

NOV 22 1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-22-23

17- I HEREBY CERTIFY, That I attended deceased from 11/9/23, 19..., to 11/34, 19..., that I last saw h... alive on 11/21/23, 19..., and that death occurred, on the date stated above, at 4:10 A.

The CAUSE OF DEATH* was as follows:

c

Cardiac Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harland Brown, M. D.

, 19 (Address) 122 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hanover

DATE OF BURIAL. 11/25, 1923

20-UNDERTAKER. Wm Cook

ADDRESS 502 E North

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Every item of information supplied. Exact statement of OCCUPATION is very important. See that it may be properly classified. Exact statement of OCCUPATION is very important. See that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

...s on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81056

CERTIFICATE OF DEATH.

X 74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 312 S. 12th ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Martin

(a) RESIDENCE NO. 312 S. 12 ST., WARD Georgia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Martin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (none) housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER William A. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S. A.

14 Informant W. E. Martin

(Address) Robert F. Harrison,

15 Filed ....., 19 ..... Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1923, to Nov. 21, 1923, that I last saw h alive on Nov. 21, 1923, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. 9 mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. S. Haar M. D.

11.21. 1923 (Address) 801 W. Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lake Cross. Ga.

DATE OF BURIAL Nov 27 1923

20 UNDERTAKER Robt. L. Cook

ADDRESS 1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OV 2 1923

D 81057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hosp St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia Boland

(Residence in Baltimore: No. 531 S Monroe St — St.; 12 yrs., 11 mos., 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Single

6-DATE OF BIRTH. December 9 1910
(Month) (Day) (Year)

7-AGE, 12 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer). girl

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Boland

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER, Cora Gerber

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cora Boland

(Address) 531 S Monroe St

15- NOV 22 1923 19.....

Robert P. Harrison,
Registrar.
~~Burial Permit Clerk.~~

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH November 20 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1c. Gas Poisoning 25 hours
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Homicide
(Duration) ....yrs. ....mos. ....ds.

(Signed) G E Weems M. D.
(Coroner.)
19?....(Address) 1437 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Nov 23 1923

20-UNDERTAKER	ADDRESS
Edw H Eawan & Son	
per E H Eawan	321 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81058

CERTIFICATE OF DEATH.

135 D 81058

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Reynolds.

(a) RESIDENCE No. 7 N. Mulrod ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
C	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Reynolds

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Munn

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland.

14 Informant Univ. Hosp. Records (Address)

15 Filed ....., 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

NOV 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1923, to Nov 22, 1923,

that I last saw h. IN alive on Nov 22, 1923

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Suppression } Uremia
Uremia. }
Chronic Benign Hypertrophy } Prostate

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) Dr. R. R. Newman M. D.

Nov. 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem Washington D.C.	Nov 24 1923
20 UNDERTAKER	ADDRESS
George J Smith	1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OV 22 1923

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81059

CERTIFICATE OF DEATH.

45

D 81059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp (ST.) 70 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret A. ~~Stuart~~ Stuart

(a) RESIDENCE NO. 2561 N. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl. 2-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	74 yrs	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Med. M. Kohn

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Stuart

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Michael

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Germany

14 Informant Mrs Agnes Fitzgerald (Address) 2061 N. Bond St

15 Filed NOV 22 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1923, to 11-21, 1923, that I last saw her alive on 11-21, 1923, and that death occurred, on the date stated above, at 4 10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
Carcinoma of Colon.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov 24 1923.

20 UNDERTAKER Elmer W. Conklin — ADDRESS 924 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81060 12H D 81060

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12 N. Fulton St. (Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lena Grady

(a) RESIDENCE. No. 12 Fulton St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. 11 mos. 24 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Grady

6 DATE OF BIRTH (month, day, and year) Dec 24/1859

7 AGE Years 63 69 Months ~~10~~ Days 28 | If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry-Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Battenburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Rosa Kwoz 1807 N. Pulaski

15 [illegible], 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

OV 221923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-1923

17 I HEREBY CERTIFY, That I attended deceased from 11-1- , 1923, to 11-22- , 1923 that I last saw h[illegible] alive on 11-22- , 1923 and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Uterus Myocondetis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable-Cholecystitis several months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Victor Richards, M. D.

, 19 (Address) Fidelity Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 24 19
20 UNDERTAKER	ADDRESS
J. B. Keppel	2236 Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81061

CERTIFICATE OF DEATH.

31 ✓ D 81061

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 McCabe ave ST., 27 WARD)

2-FULL NAME Blanche Virginia Shimp

(a) **RESIDENCE** No. 722 McCabe ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Chester E. Shimp

6 DATE OF BIRTH (month, day, and year) Nov 3, 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
23	X	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Duquesne (State or country) Penna

PARENTS

10 NAME OF FATHER Joshua E Norris

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marion E Holm

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant ..... (Address) 722 McCabe ave

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Nov 21, 1923,

that I last saw h[illegible] alive on Nov 21, 1923,

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Duncan, M. D.

Nov 22, 1923 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Nov 24 1923

20 UNDERTAKER John B. Spence — ADDRESS 1325 N. Caroline St

Spec.—1-10-21—M&T—1500 Bks.

D 81062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 81062

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Central ave ST., 10 WARD)

2-FULL NAME George D. Wollrab

(a) RESIDENCE No. 1219 N. Central ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Delmar K. Wollrab

6 DATE OF BIRTH (month, day, and year): May 11, 1871

7 AGE — Years: 52 — Months: 6 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jewelry Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo. D. Wollrab

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea H. Gruner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Delmar K. Wollrab 1219 Central ave

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 21, 1923, that I last saw him alive on Nov 20, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia & Laryngeal Tuberculosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Lafeste Ewalt M. D.

11/21, 1923 (Address) 2945 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 23, 1923

20 UNDERTAKER: Grohler & Zimken — ADDRESS: 1219 Eager

Spec.—1-10-21—M&T—1509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81063

CERTIFICATE OF DEATH.

1.61.00 D 81063

1-PLACE OF DEATH St. Agnes Hosp 19

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl allen

(a) RESIDENCE NO. 1512 Mc Henry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~11~~

6 DATE OF BIRTH (month, day, and year): Nov 18 23

7 AGE — Years: ~~1~~ | Months: | Days: 4 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jim allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary C Shea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Shea

(Address): 1512 Mc Henry st

NOV 23 1923 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-22 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1923, to 11-22, 1923, that I last saw h~~e~~r alive on 11-22, 1923, and that death occurred, on the date stated above, at 2 20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 4 days. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H S Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 11/23 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 N Fulton ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Injury at Butte.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81064 100-001 D 81064

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clark E. Hood

(a) RESIDENCE No. 1516 Millrace Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah S Hood

6 DATE OF BIRTH (month, day, and year) ? 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mill worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Albert Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Municipal Hospital Records. (Address)

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 17, 1923, to November 22, 1923, that I last saw him alive on November 21, 1923, and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude E Brace, M. D.

11-22-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 25 23

20 UNDERTAKER Chenowith Son ADDRESS 36 Chestnut

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81065

CERTIFICATE OF DEATH.

129 D 81065

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3806 Lloyd Ave. (Howard Pk) ST., 28 WARD)

2-FULL NAME James Henry Love

(a) RESIDENCE NO. 3806 Lloyd Ave. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Worthington Love

6 DATE OF BIRTH (month, day, and year) July 6. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Richmond
(State or country) Va.

PARENTS

10 NAME OF FATHER Henry Love

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Mary Amick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Ann Worthington Love
(Address) 3806 Lloyd Ave.

15 NOV 23 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1923, to Nov. 22, 1923, that I last saw him alive on Nov. 22, 1923, and that death occurred, on the date stated above, at 2:35P m.

The CAUSE OF DEATH* was as follows:

Diffuse Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) K. C. Mettel M. D.

Nov 23 1923 (Address) 1903 W. Northav.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Private Burying ground 2nd District Balto. Co. Md — DATE OF BURIAL: 11-24-1923

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N. Broadway

D 81066 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 81066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 506 Fells Road St., 27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Thompson

(Residence in Baltimore: No. 506 Fells Road St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: C.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Mar 6 (Month) (Day) 1871 (Year)

7-AGE: 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Conner Mahoney

(Address) 2109 Druid Hill Ave

15 NOV 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos H. Morrissey M. D. (Coroner)

Nov 24 1923 (Address) 672 Poplar Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peters Cemetery DATE OF BURIAL: Nov 24 1923

20-UNDERTAKER: Mac R. G. Elliott ADDRESS 172 Ashland Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81067

99-09 D 81067

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2649 Edmondson Ave (St.) 20 (Ward)

2-FULL NAME Mrs Kate Heise

(a) RESIDENCE. No. 2649 Edmondson Ave St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? Lifetime yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced (or) WIFE of: Louis C. Heise.

6 DATE OF BIRTH (month, day, and year): Apl 15/66

7 AGE: Years 57 | Months ✓ | Days ✓ | If LESS than 1 day ✓ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: None.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John H. Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Christina

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): George C. Shannon 700 Fulton Ave

NOV 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1923, to Nov 21, 1923, that I last saw her alive on Nov 20, 1923, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) ✓ yrs. ✓ mos. 5 ds.

CONTRIBUTORY (Secondary) Arteno Sclerosis

(duration) = yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George C. Shannon, M. D.

11/21, 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk — DATE OF BURIAL: Nov 23 1923

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81068

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 81068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3903 Old York Road (St.) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Pfaff Jr

(a) RESIDENCE NO. 3903 Old York Road (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 7-1862

7 AGE: Years 61- Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): with Pfaff Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md-

PARENTS

10 NAME OF FATHER George Pfaff Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany -

12 MAIDEN NAME OF MOTHER Mary Knoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Henry C Pfaff 3903 Old York Road

15 NOV 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 17 19 23, to Nov 21, 1923,

that I last saw him alive on Nov 21, 1923,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute atrophy of the liver

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual symptoms

(Signed) Wm L Peckenbaugh, M. D.

, 19 (Address) 915 Cedar and Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 23 1923

20 UNDERTAKER: W J Tichnor & Son — ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81069

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

D 81069

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2913 Sarah Ann St., 13 WARD)

2-FULL NAME Patrick Joseph Cushen

(a) RESIDENCE NO. 2918 Park Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances M Cushen

6 DATE OF BIRTH (month, day, and year): Sept 26 1866

7 AGE: Years 57 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 016

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer: Own

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frances M Cushen 2918 Park Ave

15 Filed NOV 23 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov 21, 1923,

that I last saw h alive on Nov 21, 1923,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Blood Stream infection (Septicaemia) - Streptococcus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Focus undetermined

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood culture + Spinal fluid

(Signed) Chas Smith, M. D.

Nov 23 1923 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Nov 24 1923

16 UNDERTAKER: J Kelly Sons

ADDRESS: Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 81070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. monument & Rutlerdane Hebrew Hospital ST., 5 WARD)

2-FULL NAME Mrs Louis Katz

(a) RESIDENCE NO. 48 N. Caroline St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Katz Lieberman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Baer Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1923

17

I HEREBY CERTIFY, That I attended deceased from November 13, 1923, to Nov 22, 1923, that I last saw him alive on Nov 22, 1923, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of right foot.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Amputation of right leg

Did an operation precede death? Yes Date of Nov 20/1923.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Adler Goodhartz, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew North Point & Gorsuch Hill Rd | DATE OF BURIAL Nov 23 1923

20 UNDERTAKER Jack Lewis | ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 47 ✓ D 81071

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane M. Hays

(a) RESIDENCE NO. Newville, Pa ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred --- yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Married

6 DATE OF BIRTH (month, day, and year): May 29, 1874

7 AGE — Years: 49 — Months: 5 — Days: 26 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Newville Pa

PARENTS

10 NAME OF FATHER: John S Hays

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Jennie McFarlane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Mrs Gilbert E Swope Newville Pa

15 NOV 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1923, to Nov. 23, 1923, that I last saw her alive on Nov. 23, 1923, and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast recurrent and metastatic

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C.H. Price, M. D.

Nov 23 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newville Pa. — DATE OF BURIAL: Nov 23 19 23

20 UNDERTAKER: H.W. Mears & Son — ADDRESS: 805 N Calvert St

Escort Mrs G.E. Swope Newville Pa.

Spec.—1-10-21—M&T—1500 Bks.

Ida Gutman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81072

74-001

D 81072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belmont Belvidere aves ST., 15 WARD)
(Lakewood Sanitarium)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Gutman

(a) RESIDENCE NO. 2314 W. North ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Herman Gutman

6 DATE OF BIRTH (month, day, and year) May 17 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	48	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Leopold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Goldsmith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Herman Gutman
(Address) 2314 W. North Ave

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 23rd, 1923, to Nov 21st, 1923.

That I last saw h.r alive on Nov 21st, 1923,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 1 mos 11 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? pneumonia etc.

(Signed) Benjamin Pinkuss, M. D.

Nov 23 1923 (Address) 1304 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 11/23/1923

20 UNDERTAKER David Sondheim — ADDRESS 118-120 W. Mt Royal Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81073
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

11-002

D 81073
Registered No.

City of BALTIMORE: (No. 423 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Miller

(a) Residence No. 423 S. Robinson St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam Miller

6-DATE OF BIRTH (month, day and year): June 8 1867

7-AGE: 56 yrs. 5 mos. 12 ds.

If LESS than 1 day, hrs. or min.:

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS:
10-NAME OF FATHER: Louis Verges
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Elizabeth Schmidt
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-
(Informant) Adam L. Miller
(Address) 423 S. Robinson St.

15-
Filed ..... 19?.... ROBERT R. KRAUTER,
Registrar.
NOV 23 1923
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1923 to Nov. 20 1923
that I last saw her alive on Nov 20 1923
and that death occurred, on the date stated above, at 7 30 P.m.
The CAUSE OF DEATH* was as follows:

Grippe

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Septicaemia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod M. D
, 19 (Address) 470 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov. 24, 1923

20-UNDERTAKER: H. Sanders & Sons — ADDRESS: 1710 Fleet St.

N. B.—WRITE PLAINLY, with unfading ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81074

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D 81074

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Argyle Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris G Chaney

(a) RESIDENCE NO. 906 Argyle Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Chaney

6 DATE OF BIRTH (month, day, and year): Nov. 25-1871

7 AGE — Years: 52 | Months: 11 | Days: 25 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: John Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md.

12 MAIDEN NAME OF MOTHER: Lizzie Abraham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: Robert Chaney

(Address) 906 Argyle Ave

15 NOV 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1923, to Nov 20, 1923.

that I last saw her alive on Nov 20, 1923.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 6 yrs. 6 mos 2 ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) H H Thompson M. D.

Nov. 22 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11/25 1923

20 UNDERTAKER: Samuel T Hensley

ADDRESS: Mt Auburn

Spec. 1-10-21 MXT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81075

CERTIFICATE OF DEATH.

+ 101-001 D 81075

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 452 N Bat Pk ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Toye

(a) RESIDENCE NO. 452 N Bat Pk ave ST., WARD Fullerton Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie F. Toye

6 DATE OF BIRTH (month, day, and year) Nov. 6th 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	26	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Carpet Cleaning Establishment

(c) Name of employer Chesapeake Carpet Cleaning Co.

9 BIRTHPLACE (city or town) Terra Alto

(State or country) West Virginia

PARENTS

10 NAME OF FATHER William F. Toye

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Julia Elliot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Virginia

14 Informant Mrs Marie F. Toye

(Address) Fullerton Md

15 NOV 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21/23 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1923, to Nov 21, 1923,

that I last saw h— alive on Nov 20, 1923,

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Toye M. D.

11/21, 1923 (Address) 5 N Bat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cmetery — DATE OF BURIAL Nov. 24 1923

20 UNDERTAKER Fredk Lassahn & Son — ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81076

CERTIFICATE OF DEATH.

+ 49 ✓

D 81076

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matt John Conran

(a) RESIDENCE NO. New Madrid, Mo. ST., WARD New Madrid, Mo.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. 35 ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 25, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	55	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10 NAME OF FATHER Matt Conran

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y. ✓

12 MAIDEN NAME OF MOTHER Enid Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y. ✓

14 Informant Hospital Records
(Address)

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1923, to Nov 22, 1923, that I last saw him alive on Nov 22, 1923, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma
(a) Lung metastasis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Madrid Mo. — DATE OF BURIAL: 11/23/1923

20 UNDERTAKER: Chas. F. Evans & Son — ADDRESS: 118 N. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81077

CERTIFICATE OF DEATH.

100-001

D 81077

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 E Biddle St ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. George Gehring Jr.

(Residence in Baltimore: No. ~~Eighteen~~ 610 E Biddle St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug - 1 - 1858, 1 (Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Jeweler —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City —

PARENTS.

10-NAME OF FATHER, J. Geo. Gehring

11-BIRTHPLACE OF FATHER (State or Country), Balto. City —

12-MAIDEN NAME OF MOTHER Mary L Sickels

13-BIRTHPLACE OF MOTHER (State or Country), Balto City —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr F. C. Bressler

(Address) 125 S. Broadway

15- NOV 23 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov - 22 - 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov - 19 1923, to Nov 22 1923, that I saw h— alive on Nov 22 1923, and that death occurred, on the date stated above, at 8-45 a m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) yrs. mos. 3 - ds.

CONTRIBUTORY (Secondary) Cardiac failure -

(Duration) yrs. mos. 1 ds.

(Signed) Frank C Bressler M. D.

Nov 22, 1923 (Address) 125 S Broadway —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 11/24, 1923

20-UNDERTAKER Chas R Kraus & Son

ADDRESS 118 W Mt Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81078

CERTIFICATE OF DEATH.

129 D 81078

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 2808 Hillsdale ST., 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian G. Billings

(a) RESIDENCE NO. 2808 Hillsdale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12-1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	7	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Census Bureau

(c) Name of employer M. L. Shaw

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edwin E Billings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Little-Gurney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant L Shaw
(Address) 2808 Hillsdale

15 NOV 23 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov 21, 1923,

that I last saw her alive on Nov 21, 1923,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Nephritis chronic

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Entonic blood pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington, D.C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos Dulany Thomas M. D.

Nov. 1923 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 23 19

20 UNDERTAKER J. Bernard Ford

ADDRESS 1901 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81079 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81079

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Wolfe ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Mroz

(a) RESIDENCE NO. 117 S. Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Mroz

6 DATE OF BIRTH (month, day, and year) June 19. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	40	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gas Electric Co.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer Laborer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John . Mroz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Anna Mroz
(Address) 117 S. Wolfe Street

NOV 23 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Nov 21, 1923.

that I last saw h[illegible] alive on Nov 22, 1923.

and that death occurred, on the date stated above, at 550 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation
Contract Puerperal Sepsis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 352 S Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Nov. 24 19 23

20 UNDERTAKER John M. Weber

ADDRESS 1803 Banks

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

Held by permission of Health Dept Mr. Woodward

D 81080 B

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81080

CERTIFICATE OF DEATH.

REGISTERED NO. 101-057

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. 1 ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Johnson

(a) RESIDENCE NO. Newport, N. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) " - Odd

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Charlie Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Jane —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Record (Address) Johns Hopkins Hospital

15 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

NOV 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923. to Nov 10, 1923. that I last saw him alive on Nov 10, 1923. and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) T. R. Hannon, M. D.

11/23, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov 23, 1923

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec.—8-24-14—M. & T.—2000 Blks.

D 81081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81081

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Patapsco ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Franklin Stevens

(Residence in Baltimore: No. 1613 Patapsco St.; 71 yrs., 6 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, May (Month) 10 (Day), 1852 (Year)

7-AGE, 71 yrs. 6 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lab— 040.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Robt Stevens

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Moore

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lottie Stevens

(Address) 1613 Patapsco

15- NOV 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11. 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10. 18 1923, to 11. 24 1923, that I saw h[illegible] alive on 11. 22 1923, and that death occurred, on the date stated above, at 12.40 a m.

The CAUSE OF DEATH* was as follows:

Dilatacardia

Stenosis

.... (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Aortic Stenosis (From History)

.... (Duration) 1 yrs. .... mos. .... ds.

(Signed) [illegible] M. D.

11.24.1923 (Address) 107 E. Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 11/27, 1923

20-UNDERTAKER L. F. Mc Cully

ADDRESS 1300 E. Fort

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D 81082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Light St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kendall

(a) RESIDENCE No. 1609 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard A. Kendall

6 DATE OF BIRTH (month, day, and year) Aug. 4 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	83	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriett Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Johnson

(Address) 1609 Light St

15 Filed NOV 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1923, to Nov 22, 1923

that I last saw her alive on Nov 2, 1923

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Nephritis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wilbur Bruce M. D.

11 22 1923 (Address) 1609 E Kendall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 11/24 1923

20 UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EARE should be taken that all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81083 — CERTIFICATE OF DEATH. — 162 D 81083

1-PLACE OF DEATH (Colonial Hosp.

CITY OF BALTIMORE: (No. 1122 N. Mount ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Charles Crawford

(a) RESIDENCE NO. 1516 W. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ 1 day How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1923

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer ..

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Crawford

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Helen Lane

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Father - Charles Crawford (Address) 1516 W. Lafayette.

NOV 23 1923 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Thurs. Nov. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Nov. 22, 1923

that I last saw h[illegible] alive on Nov. 22, 1923

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Since birth (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. G. Snowman, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov 23 1923

20 UNDERTAKER N M Routson — ADDRESS 2238 W Mth

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81084 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 81084

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2026 Brookfield Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Florence Wilson Goss

(a) Residence No. 2026 Brookfield Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 16 1871

7-AGE, 52 yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. nr. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Artist. Painting

(b) General nature of Industry, business, or establishment in which employed (or employer)... — 001

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Balto. County Md

PARENTS.

10-NAME OF FATHER, Wm Robt. Towen Goss

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Arlington Balto. Co. Md

12-MAIDEN NAME OF MOTHER, Elizabeth G. Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Co. Md

14- (Informant) Aimee D. Goss

(Address) 2026 Brookfield Ave

15- Filed NOV 23 1923 ROBERT R. KRAUTZ Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 21 1923

17- I HEREBY CERTIFY, That I attended deceased from Mch 14, 1923, to Nov. 21st, 1923, that I last saw her alive on Nov. 21st, 1923 and that death occurred, on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast. operated on about 2 yrs ago — Return of the trouble made this necessary.

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? yes Date of 2 yrs ago

Was there an autopsy? no Data obtained from

What test confirmed diagnosis? Don't know

(Signed) Chas. H. Burbert, M. D.

Nov. 23, 1923 (Address) 1104 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Cem. DATE OF BURIAL, Nov 23 19 23

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81085

CERTIFICATE OF DEATH.

44 D 81085

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Franklin Square Hospt ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Leonard

(a) RESIDENCE. No. 2733 W Fairmont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 7 mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward E Leonard

6 DATE OF BIRTH (month, day, and year) Mar. 28- 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry W Colehouse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Margaret Kaylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Blato, Md

14 Informant: Edward E Leonard
(Address): 2733 W FairmontAve

15 Filed NOV 23 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 19 23, to Nov 21, 19 23, that I last saw her alive on Nov 20, 19 23, and that death occurred, on the date stated above, at 5,40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2733 W Fairmount Ave

Did an operation precede death? Yes Date of 10.17.23

Was there an autopsy? No

What test confirmed diagnosis? Findings Lab.

(Signed) Edw Crouth, M. D.

11.23.23 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 24 1923
20 UNDERTAKER: Jos Joerdens Son	ADDRESS: 217 S Re

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 1324 N. Strieker or Baker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 23 1923, 19.... Registrar Robert P. Harrison, Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 20 19 23 to November 21 19 23, that I last saw him alive on November 21 19 23, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S Howe, M. D.

11-22-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn, DATE OF BURIAL 11-24 19 23

20 UNDERTAKER Patterson & Lewis ADDRESS 1313 Pennsylvania Ave

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81087

CERTIFICATE OF DEATH.

11-002 ✓

D 81087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2320 Etting ST., 14 WARD)

2-FULL NAME Mary Bailey

(a) RESIDENCE NO. 2320 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Bailey

6 DATE OF BIRTH (month, day, and year) March 8 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Co Va

PARENTS

10 NAME OF FATHER William P. Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Bobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Isabella Tate

(Address) 2322 Etting St

15 [illegible] 19 [illegible] Registrar

[Robert F.] Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1923, to Nov 21st, 1923, that I last saw her alive on Nov 20th, 1923, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Influenza (duration) — yrs — mos 10 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie, M. D.

Nov 21, 1923 (Address) 1339 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 11/24 1923

20 UNDERTAKER James A. Dennis — ADDRESS 303 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DV 23 1923

Spec.—1-10-21—M&T—1500 Bks.

D 81088 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81088

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5725 Gorsuch ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Satterfield

(a) RESIDENCE NO. 5725 Gorsuch ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lou Satterfield

6 DATE OF BIRTH (month, day, and year) May 1 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butter + Egg dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mohajan

PARENTS

10 NAME OF FATHER James Satterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Lou Satterfield

(Address) 5725 Gorsuch ave

15 Filed NOV 23 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug-1, 1923, to Nov. 22, 1923, that I last saw him alive on Nov. 22, 1923, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hearn, M. D.

11-23, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Harrington Del — DATE OF BURIAL Nov. 25 1923

20 UNDERTAKER John Lecron — ADDRESS Ellwood

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81089 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81089

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3232 Elliott St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Susanna Dannenfelser

(a) Residence No. 3232 Elliott St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If ~~married, widowed, or divorced~~ (HUSBAND of ~~for~~) WIFE of Martin Dannenfelser

6-DATE OF BIRTH (month, day and year) Oct. 27-1859

7-AGE. 64 yrs. — mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home (old)

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Carroll Co, Md.

PARENTS.

10-NAME OF FATHER, Adam Messing

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Lena Dannenfelser

(Address) 3232 Elliott St.

15- Filed Nov 24 1923 Robert P. Harrison, Registrar.

OV 231923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 20-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19th, 1923 to Nov 20th, 1923

that I last saw her alive on Nov 20th, 1923

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY —
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D.D. Jones M. D.

11-21-1923 (Address) 1013 N Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Nov. 24, 1923

20-UNDERTAKER, Zirkler + Zirkler ADDRESS 1739 E. Eager St.

WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks

D 81090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81090

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5709 York Road ST., 27 WARD)

2-FULL NAME Clarence Cookman Foreman

(a) RESIDENCE NO. 5709 York Road ST., 27 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? 49 yrs 8 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Estelle Mason Foreman

6 DATE OF BIRTH (month, day, and year) Feby-28-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney-at-Law.

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Leander Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Isabella Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Mrs Estelle M. Foreman (wife) 5709 York Road.

15 Filed ..... Robert P. Harrison, Registrar

NOV 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1923

17 I HEREBY CERTIFY That I attended deceased from Sept 3, 1923, to Nov 22, 1923, that I last saw him alive on Nov. 22, 1923 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH was as follows:

Asphyxiation
Obstruction infecting
Fetal suffocation

(duration) yrs. 2 mos 19 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) Irvine Eberle, M. D.

Nov 23 1923 (Address) 700 W 32nd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 24 1923
20 UNDERTAKER STEWART & MOWEN COMPANY WILLIAM P. WOODEN, Successor	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIANS: sta CAUSE OF DEATH in plain terms, so that it at it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on s on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81091

CERTIFICATE OF DEATH

38

D 81091

1-PLACE OF DEATH Boy View Infirmary

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, No. ..... ST., 26 WARD)

2-FULL NAME Earl Anderson Unknown

(a) RESIDENCE NO. Unknown ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893?

7 AGE Years 29? Months ..... Days ..... If LESS than 1 day, hrs. ..... or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of Industry, business, or establishment in which employed (or employer) Unk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER do

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Boy View Infirmary

(Address)

15 Filed NOV 23 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1923 to Nov. 21, 1923

that I last saw him alive on Nov. 20, 1923

and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Confusion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. J. Hedgcock, M. D.

11/23/23 (Address) Boy View Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 23 1923, 19

20 UNDERTAKER Commissioner Health, Per. Wm. E. WOODALL

ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should name CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 23 1923

Robert P. Hutton, Registrar

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81092

CERTIFICATE OF DEATH.

129

D 81092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Loveday

(a) RESIDENCE NO. 912 Boyd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records. (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 19 23

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 19 23, to Nov. 20, 19 23,

that I last saw him alive on November 20, 19 23,

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Chronic Nephritis & Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Hance, M. D.

11-21-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 23 1923 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Robert B. Harrison, M.D.

District Health Officer

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of O TION is very important. See instructions on back of certificates.

09 23 1923

Spec. 1-10-21 M&T 1500 lbs.

D 81093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-021

D 81093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 E. Henrietta st ST., 23 WARD)

2-FULL NAME Katherine Sonneborn

(a) RESIDENCE NO. 3 E. Henrietta ST., WARD 23
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Sonneborn

6 DATE OF BIRTH (month, day, and year) May 6th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Birkelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida Sonneborn
(Address) 3 E. Henrietta st

15 Filed ..... 19 .....
Robert P. Murphy
Burial Permit Clerk Registrar

NOV 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21- 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4 , 1923 , to Nov. 21- , 1923.

that I last saw h.. alive on Nov. 20th , 1923.

and that death occurred, on the date stated above, at 2.0 , m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Cardiac Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary Cook Willis , M. D.

11-23 1923 (Address) 1131 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Nov 24th 1923

20 UNDERTAKER E. Schlosser & Son

ADDRESS 1039 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in giving information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81094

CERTIFICATE OF DEATH.

1924 D 81094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Calhoun ST., 16 WARD)

2-FULL NAME Mrs. Carrie Marshall

(a) RESIDENCE No. 824 Calhoun St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augustus Marshall

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Mary Co. Maryland

PARENTS

10 NAME OF FATHER: Jefferson (last name unknown)

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Maryland

14 Informant: Edward Marshall

(Address) 824 Calhoun St

15 Filed NOV 23 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1923, to Nov 21, 1923, that I last saw her alive on Nov. 21, 1923, and that death occurred, on the date stated above, at 2:10 P m.

The CAUSE OF DEATH* was as follows:

Pan Carditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frampton Saunders, M. D.

, 19 (Address) 1128 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview Cem. | DATE OF BURIAL: 11-26 1923

20 UNDERTAKER: Geo. A. Gibson | ADDRESS: 1733 Howard Hill ave

B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE sh... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on b... CA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 81095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81095

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.: Chestnut Hill Ave WARD 9)

2-FULL NAME Philip Gaines

(a) RESIDENCE. No. St. Elizabeths Home ST., Chestnut Hill Ave WARD. Boston Mass.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8-1921

7 AGE 2 Years 3 Months 15 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Born Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Philip Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Izabella Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

11 Informant St Elizabeths Hom
(Address) Chestnut ave

15 Filed NOV 23 1923 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22 1923

17 I HEREBY CERTIFY, That I attended deceased from November 21, 1923, to November 22, 1923, that I last saw him alive on November 22, 1923 and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Convulsions (no primary cause)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis J. Ayd, M. D.

Nov 23, 1923 (Address) 2006 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-24 1923
20 UNDERTAKER George J. A. Gibson	ADDRESS 1735 Harlem Ave

N. B.—WHITE PLAINLY. WITH LEAD PENCIL. NAME should be stated EXACTLY. PHYSICIANS should be careful. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81096

CERTIFICATE OF DEATH.

D 81096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 E. Henrietta St. St., 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Henry Fisher.

(a) RESIDENCE NO 30 E. Henrietta St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE~~ of Louisa Fisher.

6 DATE OF BIRTH (month, day, and year) August 26, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	2	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Cigar box
(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Fisher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER ~~-------~~ ~~-----~~.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Louisa Fisher. (wife).
(Address) 30 E. Henrietta St.

15 Filed NOV 21 1923, 192

Robert E. Harrison.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Illuminating Gas Poisoning.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Nov, 28, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 24 1923
20 UNDERTAKER	ADDRESS
H. G. Lehner & Son	Park Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81097 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81097

CERTIFICATE OF DEATH.

122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 Carroll ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Duvall

(a) RESIDENCE NO. 124 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Duvall

6 DATE OF BIRTH (month, day, and year) Oct. 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	2	

8 OCCUPATION OF DECEASED Packer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Bargain H Frederick Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Deitzelbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Emma V Duvall

(Address) 124 Carroll St.

15 Robert P. Harrison, .19

Burial Permit Clerk Registrar

OV 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Nov 22, 1923.

that I last saw him alive on Nov 21, 1923

and that death occurred, on the date stated above, at 4 15 AM

The CAUSE OF DEATH was as follows:

Hypostatic Congestion

Broncho Pneumonia 2 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophic Cerrhosis

Repated (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Dk

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) M G Finnegan M. D.

11-22-23 (Address) 68 W Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem DATE OF BURIAL Nov 24 1923

20 UNDERTAKER Wm Huckerkons ADDRESS North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Dr. Freilinger

682 Columbia Ave.

Phone 6605

Spec.—1-10-21—M&T—1500 Blks.

D 81098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D 81098

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp 27 ST. WARD)

2-FULL NAME Frank F. Willenburg

(a) RESIDENCE NO. Grove Ave & Harf. Rd ST. Hamilton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of [redacted] WIFE Flora Willenburg

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor Trimmings

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Willenburg (Address) Hamilton Robert T. Harrison

Filed NOV 23 1923, 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1923, to Oct. 20, 1923, that I last saw him alive on Oct. 20, 1923, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Cholelithiasis

Jaundice

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? Yes Date of 11/19/23

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) A. W. Braun, M. D.

11/21 1923 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 11/24/23

20 UNDERTAKER Geo. J. Pulk

ADDRESS 1705 Harford

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81099

CERTIFICATE OF DEATH.

X 57 D 81099

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Green (St.) 4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Price

(a) RESIDENCE NO. Cockeysville Md (St.), (Ward) Cockeysville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64			—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer No

9 BIRTHPLACE (city or town) Cockeysville Md (State or country) Maryland

PARENTS

10 NAME OF FATHER John Quincy Price

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Ann Price

13 BIRTHPLACE OF MOTHER (city or town) St Louis (State or country)

14 Informant University Hospital (Address)

15 ..., 19 ... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23/23

17

I HEREBY CERTIFY, That I attended deceased from Nov 23 2 pm, 1923, to Nov 23, 1923, that I last saw h[illegible] alive on Nov 23, 1923, and that death occurred, on the date stated above, at 6.25 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not Known.

Did an operation precede death? No Date of 11/23/23

Was there an autopsy? No

What test confirmed diagnosis? Blood acetone & Sugar

(Signed) W Wallace Walker, M. D.

, 19 (Address) Lombard & Green Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherwood Cemetery, Cockeysville Md — DATE OF BURIAL 11/24 1923

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 1055 N. Calvert St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. ... should be stated EXACTLY. PHYSICIAN'S ... should be carefully supplied. AGE should be stated EXACTLY. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DV 231923

Spec.—1-10-21—M&T—1500 Bks.

(Kaneen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81100

CERTIFICATE OF DEATH.

D 81100

1-PLACE OF DEATH

CITY OF BALTIMORE: (N.) St. Joseph's Hosp. ST., (WARD)

2-FULL NAME Baby Kaneen. Eastern Town

(a) RESIDENCE NO. Balto Co Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 161-

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 20 / 23

7 AGE: Years — Months — Days: 3 days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Arther Kareen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co

12 MAIDEN NAME OF MOTHER: Tillie M. Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Arther Kareen

(Address): Registration Balto

15 Date Received: NOV 24 1923 Robert F. Harrison R. F. D. Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Nov 23, 1923, that I last saw him alive on Nov. 23, 1923, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Contracted Fibrio Mother Cesarean Section

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) J. H. Schenick M. D.

(Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cem Towson Md — DATE OF BURIAL: Nov 24 23

20 UNDERTAKER: Jobry Bros Sons — ADDRESS: Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT MUST BE COMPLETED IN FULL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81101 Charles Berg

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D 81101

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 27 WARD)

2-FULL NAME Chas. Berg

(a) RESIDENCE NO. 5004 Wilson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene C VanHorn Berg

6 DATE OF BIRTH (month, day, and year): Nov-24-1896

7 AGE: Years 27; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: U.S. Ft. & G. Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Chas. W Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Kate Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Hospital Records

(Address)

15 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 24 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each question should be carefully answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 - , 1923, to Nov-22 , 1923, that I last saw him alive on Nov-21 , 1923 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis (Pulmonary)

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Symp. Phys. Exam.

(Signed) 2K Baetjer M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 11/24/1923

20 UNDERTAKER: C. D. Fleming & Son

ADDRESS: 1916 E. Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81102

CERTIFICATE OF DEATH.

74-601

B 81102

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 S Bethel St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Dixon

(Residence in Baltimore: No. 244 S Bethel St.; Life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Unknown (Month) ..... (Day), 1856 (Year)

7-AGE, 67 Yrs Approx mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gen. Sewell Grandson

(Address) 244 S Bethel St

15-

Filed....., 192.. Robert P. Harrison, Registrar.

DV 241923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) ..... 20 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923, to Nov 20 1923, that I saw h-w alive on Nov 19 1923, and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
& Hypertension
unknown
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Facial Paralysis due to cerebral hemorrhage
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) R J Young M. D.

11/24 1923 (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Nov. 24th, 1923

20-UNDERTAKER Milton Davis — ADDRESS 315 N Eden St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81103

B 81103

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No.) 1432 Park avenue (ST.) 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Dalrymple Williams

(a) RESIDENCE NO. 1432 Park ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 16th Oct 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nathaniel Williams

11 BIRTHPLACE OF FATHER (city or town) Roxbury (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Maria P. Dalrymple

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Edw Lyon Gibson (Address) 1809 Munsey Bldg Baltimore Md

15 Filed NOV 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 1923, to Nov 22, 1923, that I last saw her alive on Nov. 22, 1923, and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) ✓ yrs. ✓ mos 2 ds.

CONTRIBUTORY (Secondary) Absolutely [illegible]

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? ✓

(Signed) Edw Lyon Gibson, M. D.

11/23, 1923 (Address) 1809 Munsey Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Nov 26 1923

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS Richard and Talbot

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DV 24 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Myocarditis

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81104

CERTIFICATE OF DEATH.

129 D 81104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp St. 12 WARD)

2-FULL NAME Edward L. Hudson

(a) RESIDENCE NO Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ex Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Frank. Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Canfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minna Hudson
(Address)

Filed NOV 24 1923 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bright's Disease
Acute Cardiac dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. Kelly, M. D.

(Address) 1857 Lombard

Nov 23 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 4 hrs. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Nov 26 1923
20 UNDERTAKER Henry H. Jenkins Sons	ADDRESS McCulloh

Any be properly classified. Exact statement of OCCUPA-
plain terms, so that it may be
important. See instructions on back of
ck of certificate.

Spec.—1-10 21—M&T—1500 Blks.

D 81105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81105

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

2-FULL NAME Caroline Rawley

(a) RESIDENCE NO. 13 S. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Simon Rawley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Rollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Municipal Hospital Records.

15 Filed NOV 24 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1923, to Nov. 20, 1923, that I last saw her alive on November 19, 1923, and that death occurred, on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Final)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Dorsey, M. D.

11-20-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL Nov. 25 1923

20 UNDERTAKER Mrs J. G. Locks

ADDRESS 1302 Jeffers

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

Dr Brain, 1227 North Blvd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81106

CERTIFICATE OF DEATH.

90 D 81106

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1737 Braddish Ave. ST., 15 WARD)

2-FULL NAME Rose B Roper

(a) RESIDENCE NO. 1737 Braddish Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence H Roper

6 DATE OF BIRTH (month, day, and year) May 4 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lindsey Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Lawrence Roper
(Address) 1737 Braddish Ave

12 Robert P. Harrison, Registrar
NOV 24 1923 .19 Purial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-1-, 1923, to 11-23-, 1923

that I last saw h~~e~~ alive on 11-23-, 1923

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of Heart

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Hypertension Heart Disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hilliard Adams, M. D.

, 19 (Address) 1227 North Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Md.

DATE OF BURIAL Nov 26 1923

20 UNDERTAKER W W Cook

ADDRESS 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

(or Monterey) 3632 Rokeby Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81107

CERTIFICATE OF DEATH. 159-002 D 81107

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 Whitridge St. WARD)

2-FULL NAME Nelson Overton Holland Jr

(a) RESIDENCE NO 304 Whitridge ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER? Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nelson Holland
(Address) 304 Whitridge Ave

15 Filed ..... 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison, M. D.
(Coroner.)

Nov 23, 1923 (Address) 3602 Rokeby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Lawn Cemetery — DATE OF BURIAL Nov 24th 1923

20 UNDERTAKER William Cook — ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81108

D 81108

118-802

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 E. Castle, ST., W WARD)

2-FULL NAME Wladyslaw Karwacki

(a) RESIDENCE NO. 239 E. Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 23 - 23

7 AGE: Years: — Months: 5 Days: 2 If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Frank Karwacki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Alexandra Kotowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Karwacki
(Address): 239 E. Castle St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

NOV 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1923 to Nov. 27, 1923

that I last saw h[illegible] alive on Nov. 24, 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Flem

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gustav Kentowski, M. D.

, 19 (Address) 2529 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 25 1923

20 UNDERTAKER: J. W. Czaczuski — ADDRESS: 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81109

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Penna. Ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. M. Mathews

(a) RESIDENCE NO 1915 Pennsylvania ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Mathews

6 DATE OF BIRTH (month, day, and year) May 25, 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37 yrs.	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Marie Mathews
(Address) 1915 Penna. Ave.

15 Filed NOV 24 1923, 192 Registrar Robert E. Harrison, Registrar Vital Records Board of Health

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Nov. 22, 1923 (Address) 280 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem'y — DATE OF BURIAL 11/24/1923

20 UNDERTAKER George A. Gibson — ADDRESS 1235 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 24 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81110

CERTIFICATE OF DEATH.

161-00 D 81110

REGISTERED NO.

(If death occurred in a hospital or institution give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 5th St. WARD 16)

2-FULL NAME Infant of John and Catherine Miller

(a) RESIDENCE. No. 1335 5th St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-24-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.
		about 6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Catherine Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant (Address) John Miller 1335 5th St

15 Filed NOV 24 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 24 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-24, 1923, to 11-24, 1923,

that I last saw him alive on 11-24, 1923,

and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Miller, M. D.

(Address) 3326 Falls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 24 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 Broadway

N.B.—WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK. ALL INFORMATION SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81111

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 753 Madison ave St., 13 WARD)

2-FULL NAME Herbert Ullman

(a) RESIDENCE No. 753 Madison ave St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
20	✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Medse

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Eli Ullman

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Julia Solomon

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Julia Solomon Ullman
(Address) 753 Madison ave

15 Filed NOV 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

OV 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21 1923 to Nov 22 1923, that I last saw him alive on Nov. 22 1923, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 14 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uremia

(Signed) Howard Kelly M. D.

Nov 23 1923 (Address) 2434 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sheb Shalom Cem DATE OF BURIAL 11/25 1923

20 UNDERTAKER J Ahrens Co ADDRESS 16 N Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81112

CERTIFICATE OF DEATH.

D 81112

7H-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 697 W. Howard St. 11 WARD)

2-FULL NAME Sarah Benesch

(a) RESIDENCE NO. 898 N Howard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ~~1840~~ 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Est~~	82 (82.0)			

8 OCCUPATION OF DECEASED Jan 3 1924.

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Herman Fainly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER ~~Dant~~ Kraut Nov 23 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Levy

(Address) 898 N Howard

15 Filed NOV 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923, to Nov 23, 1923

that I last saw her alive on Nov. 21, 1923,

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial - Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral - Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G Owens M. D.

(Address) 35-4 Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 11/25 1923

20 UNDERTAKER H. Abrams & Son — ADDRESS 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE DATA REQUIRED UNDER EACH HEADING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81113

CERTIFICATE OF DEATH.

D 81113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., Municipal Tuberculosis Hospital WARD) 9

2-FULL NAME Rebecca Ferguson

(a) RESIDENCE NO. 617 Brant st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M. T. H.

15 Filed NOV 24 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to Nov. 21, 1923, that I last saw h er alive on Nov. 21, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Terminal broncho pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray, sputum

(Signed) L. C. Kelly, M. D.

11-21-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health.	ADDRESS NOV 24 1923

Dr. Wm. E. Woodall

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81114 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 81114

CERTIFICATE OF DEATH. + 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Warder

(a) RESIDENCE No. 118 Birch St., Grafton, W. Va. WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 24. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grafton, W. Va.

PARENTS

10 NAME OF FATHER Dr. A. S. Warder

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Minnie Hall Straw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Dr. A. S. Warder

(Address) Robert P. Harrison,

Filed NOV 24 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923, to Nov. 23, 1923, that I last saw him alive on Nov. 23, 1923, and that death occurred, on the date stated above, at 9 30 p.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia from infection of face.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carbuncle, lower lip

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 20, 21, 22nd

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) P. B. Price, M. D.

11/23 1923 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Grafton W Va

DATE OF BURIAL 11 27 1923

20 UNDERTAKER J. P. Talley Home

ADDRESS 1318 Eighth St

086

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81115

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1415 S Charles (ST.) (WARD) 23

2-FULL NAME Peter H. Bushey.

(a) RESIDENCE. No. 1415 S Charles St. ST., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ the late Helen Bushey

6 DATE OF BIRTH (month, day, and year) 7 July 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B C & A. Steamboat Co.

9 BIRTHPLACE (city or town) (State or country) Jones Edwards Md.

PARENTS

10 NAME OF FATHER A. Bushey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

14 Informant Mrs Florence E Browne
(Address) 1415 S Charles St

15 Filed NOV 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Nov 23, 1923, that I last saw him alive on Nov 22, 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Cirrhosis Prostatis, Hypostatic Pneumonia

(duration) mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Norbert G Mitch, M. D.

11/23 1923 (Address) 215 W Fayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Pk Cemetery Nov 26 1923

20 UNDERTAKER — ADDRESS

A. Howard Evans 1458 S Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 24 1923

Spec.—1-10-21—M&T—1500 Bks.

D 81116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81116

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital Monument St ST., 20 WARD)

2-FULL NAME Helen Bowen

(a) RESIDENCE NO. 610 S Payson St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Warner Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Dasie M Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Daisy A Bowen

(Address) 610 S Payson St

15 Filed NOV 24 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/18/23, 1923, to 11/23/23, 1923, that I last saw h e alive on Fri. 11/23, 1923 and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Septicemia c meningitis (Pneumococcus)

meningitis - 1 day

Septicemia (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Empyema of Pneumonia (duration) yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 4, 1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Roger G. Webster, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Melvile, Elkridge Md — DATE OF BURIAL Nov 25 19 23

20 UNDERTAKER: John J Fields 1200 N Fremont — ADDRESS

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lobar Pneumonia

Spec.—1-10-21—M&T—1500 Bks.

D 81117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81117

CERTIFICATE OF DEATH.

31

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

2-FULL NAME Anthony Kreinhofer (Kreinhofner)

(a) RESIDENCE NO. 1400 N. Bond st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Kreinhofer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Boehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hospital Records

(Address) M. T. H.

15 NOV 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Nov. 24, 1923.

that I last saw h im alive on Nov. 24, 1923.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum.

(Signed) L. A. Lally, M. D.

11-24-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Nov. 26 1923

20 UNDERTAKER Henry Hock Son — ADDRESS 130 E Eager st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS PAPER BECOMES A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shou CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81118 D 81118

CERTIFICATE OF DEATH. 74-007

1-PLACE OF DEATH Homewood Hosp REGISTERED NO. C

CITY OF BALTIMORE: (No. 2724 N Charles St. 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jane Evans Stoltz

(Residence in Baltimore: No. 1816 Madison St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, September 23, 1849 (Month) (Day) (Year)

7-AGE, 74 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H. Evans

11-BIRTHPLACE OF FATHER (State or Country), Harford County Md

12-MAIDEN NAME OF MOTHER Mary Ann Armstrong

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Stoltz

(Address) 1816 Madison Ave

15-

Filed Nov 24 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May, 1923, to Nov 23 1923, that I saw h alive on Nov 23 1923 and that death occurred, on the date stated above, at 6.35 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) D. L. Fellows M. D.

11/24, 1923 (Address) 2724 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. State all her life yrs. mos. ds.

Where was disease contracted, if not at place of death? 1816 Madison

Former or usual residence 1816 Madison Ave

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem — DATE OF BURIAL, Nov 27, 1923

20-UNDERTAKER George J. Smith — ADDRESS 1532 Hollins St

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

81119

D 81119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81119

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (ST.) (WARD)

2-FULL NAME Frank Barnes

(a) RESIDENCE NO. City Jail (30 days) WARD Youngstown Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Unkn.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: "

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: 42 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unkn.

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unkn. Youngstown Ohio.

PARENTS

10 NAME OF FATHER: Wm. T. Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): do Youngstown O.

12 MAIDEN NAME OF MOTHER: Catherine Fizzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Youngstown

14 Informant: F. W. Barnes. (Address) Youngstown Ohio.

15 Filed NOV 25 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 23 1923

17 I HEREBY CERTIFY That I attended deceased from November 22 1923 to Novemb 23 1923, that I last saw him alive on Novemb. 23, 1923, and that death occurred, on the date stated above, at 4 55 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Alcoholism. 2

Ibid. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinic & Autopsy.

(Signed) F. H. Leverett, M. D.

11/24/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Youngstown. O. DATE OF BURIAL: 11/24/1923

20 UNDERTAKER: Margaret L. Flynn ADDRESS: 422 High St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81120

CERTIFICATE OF DEATH.

90 D 81120

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2121 E. Lombard St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margolia Rosenstein

(a) Residence No. 2121 E Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry Rosenstein

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lauris

(Address) 1439 E Balto St

15-

FILED NOV 25 1923 By ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/24/23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22, 19 23, to Nov. 22, 19 23, that I last saw h. alive on Nov. 19 23, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Hypertension, Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. G. Maclellan M. D.

, 19 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Hebrew Russdale

DATE OF BURIAL. Nov. 25 19 23

20-UNDERTAKER. Jack Lauris

ADDRESS 1439 E. Balto.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81121

CERTIFICATE OF DEATH.

23 D 81121

REGISTERED NO.

1-PLACE OF DEATH Enroute from 2003 E. Pratt St.,

CITY OF BALTIMORE: (No. to Hebrew Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Berman

(a) RESIDENCE NO 2003 E. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk- U.S.Government
(b) General nature of industry, business, or establishment in which employed (or employer) Wash. D.C.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila., Pa.

PARENTS

10 NAME OF FATHER Morris Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel Blumberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila., Pa.

14 Informant Jack Lewis
(Address) 1439 E. Balto. Md.

15 Filed NOV 25 1923, 192 ROBERT R. KRAMER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lethargic Encephalitis

(duration) 3 or 4 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Wales, M. D. (Coroner.)

Nov 24/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rawing Rem DATE OF BURIAL Nov. 25 192 3

20 UNDERTAKER Jack Lewis, 1439 E. ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81122

CERTIFICATE OF DEATH.

13 D 81122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 S. Bond ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josepha Wisniewski

(a) RESIDENCE NO. 31- 3d. aar. Wagners Pl. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 23-1922

7 AGE: Years 1 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Anthony Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Agnes Czerniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Anthony Wisniewski 31 Wagners Pl

15 Filed NOV 25 1923 Registrar

ROBERT R. KRAUTER, Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 1923 to Nov 24 1923

that I last saw h[illegible] alive on Nov. 23 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ryczewski M. D.

(Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: William Fiaskowski

ADDRESS: 618 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81123

CERTIFICATE OF DEATH.

90 D 81123

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1473 Woodall ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Muehlhause

(a) RESIDENCE NO. 1473 Woodall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH PENCIL OR INK. THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilhelm Muehlhause

6 DATE OF BIRTH (month, day, and year): July 11 1856

7 AGE — Years: 67 Months: 4 Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Johannes. Spiess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Otto Muehlhause

(Address) 56 Rensford

15 Filed NOV 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Nov 23, 1923, that I last saw him alive on Nov 23, 1923, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Abdominal Fistula

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Thos. F. Stevens, M. D.

11/23, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loder Hill Cemetery

DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: Robt J Turner Inc

ADDRESS: 14 W. Lanvale

Spec.—1-10-21—M&T—1500 Bks.

D 81124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 81124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4023 Belle Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett E. Willhide

(a) RESIDENCE No. 4023 Belle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad A Willhide

6 DATE OF BIRTH (month, day, and year): Sept 26-1836

7 AGE — Years: 87. Months: 1 Days: 26. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Geo Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Charlotte Trostel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robert H. Willhide

(Address): 506 N. Stricker St.

15 Filed ..... 19 ..... Registrar

NOV 25 1923 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Nov 23 1923, that I last saw h[illegible] alive on Nov 23 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows: Cerebral Sclerosis

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cardiac Hypertrophy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) — Walter Wilson, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E. Mortimer 524 N. Fulton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81125

CERTIFICATE OF DEATH.

31 D 81125

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 102 Cornhill Road ST., W. WARD)

2-FULL NAME Emma S. Rodeman.

(a) RESIDENCE NO. 102 Cornhill Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jed. Rodeman.

6 DATE OF BIRTH (month, day, and year) Jan 6-1856

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Balt. (State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Speller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) J. Geo Rodeman 102 Cornhill Road.

15 Filed NOV 25 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Nov 23 1923,

that I last saw h alive on Nov 23 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Microscopic

(Signed) Geo. W. Mortimer, M.D.

, 19 (Address) 524 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemet. DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 913 S. Paca St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Ebert

(a) Residence No. 913 S. Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Fouty

6-DATE OF BIRTH (month, day and year) June 9 1868

7-AGE. 55 yrs. 5 mos. 14 ds. If LESS than 1 day old ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steamfitter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Swindale Bros

9-BIRTHPLACE (city or town) (State or Country), Balt Md.

PARENTS.

10-NAME OF FATHER, Chas. W. Ebert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Mary E. Fouty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt.

14- (Informant) Mrs. Elizabeth Ebert

(Address) 913 S. Paca St.

15- Filed NOV 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1923, to Nov 23, 1923, that I last saw h. in alive on Nov 23, 1923, and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. Finley Stone, M. D.

Nov 24 1923 (Address) 729 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL, London Park DATE OF BURIAL, Nov. 26 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 81127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 ✓ D 81127

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. All questions must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2426 Druid Hill St. 13 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Brown

(a) RESIDENCE. (Usual place of abode) No. 2426 Druid Hill St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Brown

6 DATE OF BIRTH (month, day, and year) Aug 29, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer School Board.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George A Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Moquett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Florence Brown

(Address) 2426 Druid Hill Ave

15 Filed NOV 25 1923 Registrar ROBERT R. KRAUSE Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923, to Nov 23, 1923, that I last saw h alive on Nov 22, 1923, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Fa Tuppe

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) William [illegible] M. D.

Nov 23, 1923 (Address) 1207 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 26 1923

20 UNDERTAKER Samuel H. Cole & Son ADDRESS 400 Mosher

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81128

CERTIFICATE OF DEATH.

100-001

D 81128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Thomas Campbell

(a) RESIDENCE No. 34 N Bruce St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH CAPITAL LETTERS. THE BLANKS MUST BE FILLED EXACTLY. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SIGNATURE is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): May 4 1923

7 AGE: Years ..... Months 5 Days 22 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Norman Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucille Hazard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Record

(Address) 1411

15 Filed NOV 25 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8 -, 19 23 to Nov 23, 19 23, that I last saw him alive on Nov 23, 19 23, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of thigh

(duration) yrs. ..... mos 19 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Nov. 9

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. W. Wood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov 25 19 23

20 UNDERTAKER: Brown & Ireland

ADDRESS: 1411

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81129

CERTIFICATE OF DEATH.

90

D 81129

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 703 N. 34 St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ellen Isabelle Burrier

(Residence in Baltimore: No. 703 N. 34 St

St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 31 (Day), 1879 (Year)

7-AGE, 44 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER, D. W. Allen

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Isabelle Boyer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Raymond Burrier

(Address) 703 N. 34 St

15-

Filed ....., 191.... Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk.

NOV 23 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) ....find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner.)

Nov 24, 1923 (Address) 3532 Pall Mall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Nov 26, 1923

20-UNDERTAKER A. B. Marshall

ADDRESS 2534 Pall Mall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81130

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 E. Decker Ave. ST., WARD)

2-FULL NAME Catherine Rauh

(a) RESIDENCE No. 707 E. Decker Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Rauh.

6 DATE OF BIRTH (month, day, and year) Oct. 23-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	61	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Polack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Joseph A. Rauh 707 E. Decker Ave

15 NOV 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from 11/19/23, 19..., to 11/21, 19 23.

that I last saw her alive on 11/20, 19 23,

and that death occurred, on the date stated above, at 1.43 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. H. McGarrell, M. D.

11/24 19 23 (Address) 633-S-31

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov 26 1923
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81131

CERTIFICATE OF DEATH.

100-001

100 D 81131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 S Fourth ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Schlee.

(a) RESIDENCE No. 800 S. Fourth St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Schlee

6 DATE OF BIRTH (month, day, and year): Aug 6-1887.

7 AGE: Years 36 Months 3 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brickmason.

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Henry Schlee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Emma Mueller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. Barbara Schlee (Wife)

(Address): 800 S. Fourth St.

15 Filed NOV 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1923.

17

I HEREBY CERTIFY, That I attended deceased from 11-23, 1923, to 11-24, 1923, that I last saw him alive on 11-24, 1923 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

18 hours (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell, M. D.

, 19 (Address) 156 N Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Nov. 27 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 E Monument St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81132

CERTIFICATE OF DEATH.

90 D 81132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 E. Clinton ST., 26 WARD)

2-FULL NAME Sabina Wehner

(a) RESIDENCE NO. 1001 E. Clinton ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip Wehner

6 DATE OF BIRTH (month, day, and year): May 27 1841

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Riedel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Andrew Polig Blythe 1001 E. Clinton St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to Nov. 22, 1923, that I last saw h alive on " " 19 " and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas - facial

(duration) — yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary): Valv Heart disease

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Ballenberger M. D.

Nov. 24 1923 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Nov. 26 1923

20 UNDERTAKER: Lilly & Zeller

ADDRESS: 403 S. Wolfe St

NOV 25 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics, BALTIMORE, MD.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

31133

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

101 B 31133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lawless.

(a) RESIDENCE NO. 228 N. Camden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 023

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Work.

(c) Name of employer Balto. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Patrick Lawless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record.

(Address)

15 Filed NOV 25 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25/23

17 I HEREBY CERTIFY, That I attended deceased from 11/21/23, 19..., to 11/25/23, 19...

that I last saw h[illegible] alive on 11/25/23, 19...

and that death occurred, on the date stated above, at 10.45-a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Chr. alcoholism + Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Goldy, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivy Cathedral

DATE OF BURIAL Nov 28 1923

20 UNDERTAKER J. J. Bowman & Son

ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION REQUESTED MUST BE GIVEN EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81134

CERTIFICATE OF DEATH.

D 81134

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 60 E. Randall ST., 23 WARD)

2-FULL NAME John Hartman

(a) RESIDENCE NO. 60 E. Randall ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPERATIVE. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Hartman

6 DATE OF BIRTH (month, day, and year): aug 4. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer): B&O. R.R. Shops

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS

10 NAME OF FATHER: Nicholas Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Mathilda Legg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md

14 Informant (Address): Mrs. Mary E. Hartman 60 E. Randall St

15 Filed NOV 25 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Nov 22, 1923

that I last saw h alive on Nov 22, 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

Nov 23 19 23 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: Nov. 26 1923

20 UNDERTAKER: Margaret S. Flynn — ADDRESS: 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

D 81135

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D 81135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp. St., Balto WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Karczewska

(a) RESIDENCE NO. 413 S Chapel St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Karczewska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lena Jakopska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany Poland

14 Informant Father.
(Address) 413 S Chapel St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-1923

17 I HEREBY CERTIFY, That I attended deceased from 11-23-1923 to 11-24-1923, that I last saw h. alive on 11-24-1923, and that death occurred, on the date stated above, at 8 45 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive culture K L

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Nov 26 1923

20 UNDERTAKER John Waldeber

ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD, and should be carefully examined before signing. Every question should be answered, or a reason given for the omission. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81136

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 81136

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Lanvale ST. 17 WARD)

2-FULL NAME Angeline R.R. Norman

(a) RESIDENCE NO. 113 E. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Norman

6 DATE OF BIRTH (month, day, and year): Oct 7 1847

7 AGE — Years: 76 — Months: 1 — Days: 16 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Fredk Co Md.

PARENTS

10 NAME OF FATHER: Jacob Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredk Co. Md

12 MAIDEN NAME OF MOTHER: Windsor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Chas. E. Norman Jr.
(Address) Sykesville Md.

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

NOV 26 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from November 20th 1923 to November 23rd 1923,

that I last saw h[illegible] alive on November 23rd 1923,

and that death occurred, on the date stated above, at 10th P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Personal observation,

(Signed) Wm Conrad Bodde, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmony M.E. Church Md — DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: Wm Fleckner & Sons — ADDRESS: Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81137

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Belvedere Apartments

CITY OF BALTIMORE: (No. Belvedere & Elsmere ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Rebecca Stems

(a) RESIDENCE NO. Belvedere & Elsmere ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sutton S. Stems

6 DATE OF BIRTH (month, day, and year): July 24 1867

7 AGE: Years 56 Months 3 Days 26

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Sutton S. Stems

(Address): Belvedere Apts

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923, to Nov. 24, 1923, that I last saw her alive on Nov. 24, 1923, and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia — 2 da

myocarditis — 2 wks —

(duration) yrs ..... mos ..... ds.

CONTRIBUTORY (Secondary) Diabetis arterial hypertension - (2 yrs). Chr. nephritis. (duration) yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis.

(Signed) Louis H. Krumrein M. D.

, 19 (Address) 722 North Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: H. J. Weidner & Son — ADDRESS: North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT IN FULL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REGISTERED NOV 26 1923 ROBERT P. KRAUTER REGISTRAR OF VITAL STATISTICS BUREAU OF PUBLIC HEALTH

Cor.—1-12-23—M&T—100 Bks.

D 81138 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81138

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 S. Sharp St. ST., 23 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Gregory.

(a) RESIDENCE NO 1020 S. Sharp ST. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 2. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married ~~widowed, or divorced~~ ~~(HUSBAND) not~~ (or) WIFE of Arthur O. Gregory.

6 DATE OF BIRTH (month, day, and year) September 24, 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	2	2.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Emory S. Glass.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma E. ------.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Arthur O. Gregory. (husband).
(Address) 1020 S. Sharp St.

15 Filed NOV 26 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24, 1928. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos, ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Nov. 25th, 1928. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL 11/26 1923

20 UNDERTAKER W. J. Jenkins & Son Funeral Directors ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81139

CERTIFICATE OF DEATH.

129 D 81139

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 622 Granville ST., 17 WARD)

2-FULL NAME Mary Broadway

(a) RESIDENCE No. 622 Granville ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Broadway

6 DATE OF BIRTH (month, day, and year) March 31-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boarding House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Houston Tex

PARENTS

10 NAME OF FATHER Jeff Wade

11 BIRTHPLACE OF FATHER (city or town) Baton Rouge (State or country) La

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Baton Rouge (State or country) La

14 Informant Elnora Johnson

(Address) 622 Granville

15 Filed NOV 26 1923 ROBERT R. KRAUSER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to Nov 24, 1923, that I last saw her alive on Nov 24, 1923, and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria Casts

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 11-27-1923

20 UNDERTAKER David Garrod — ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81140

CERTIFICATE OF DEATH.

90 ✓ D 81140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 W Saratoga St., 18th WARD)

2-FULL NAME Effie C Clayton

(a) RESIDENCE NO. 1120 W Saratoga ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fml. | 4 COLOR OR RACE Colrd | 5 Single, Married, Widowed, or Divorced. (write the word) Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE 49 Years | Months | Days | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Priv

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md Unknown

14 Informant Mrs Corbin
(Address) 1120 W Saratoga

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 19 , to Nov 22, 19 ,

that I last saw her alive on Nov 22, 19

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulm Congestion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood M. D.

Nov 23, 19 (Address) 9 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-26 1923

20 UNDERTAKER David Easton

ADDRESS 916 Eutaw

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81141 29 D 81141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Ward ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilliard Plately

(a) RESIDENCE NO. 1418 Ward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Plately
(Address) 1418 Ward St

15 Filed NOV 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Defined
Acc. Fall. Cut. Elbow

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. 3 ds.

(Signed) Geo Edwin Reads, M. D.
(Coroner)

Nov 23 1923 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant

DATE OF BURIAL 11-26 1923

20 UNDERTAKER Hamel Eaton

ADDRESS 916 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec— 23-21—E.B.R.S.—400 Bks.

D 81142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81142

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 W. Hill St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joshua Dixon

(a) Residence No..... 129 W. Hill St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) — 1881

7-AGE. 42 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Day Labor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Jack Dixon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md

12-MAIDEN NAME OF MOTHER, Callie —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14- (Informant)..... Annie Dixon

(Address)... 129 W. Hill St

15- NOV 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 23-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1923 to Nov 23 1923, that I last saw h. alive on Nov 23 1923 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Interval Hypertension

(Duration) ? yrs. ? mos. ? ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) [illegible] M. D.

Nov 24 1923 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Nov 26 1923
20-UNDERTAKER. John H. Teadvine	ADDRESS 142 W. Hill St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably Suicide

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81143

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. D 81143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 Linden Pkwy (ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Tripp

(a) RESIDENCE NO. 924 Linden Pkwy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wh'd

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 14th 1923

7 AGE: Years — Months — Days 10 If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Earl Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie Tripp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Annie Tripp (Address): 924 Linden Pkwy

15 Filed NOV 26 1923 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/24 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Nov 24, 1923,

that I last saw h[illegible] alive on 11/24, 1923,

and that death occurred, on the date stated above, at 1.50P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Gustav W Erlemann, M. D.

, 19 (Address) 1618 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: Nov 28 1923

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 2318 Eutaw

D 81144

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 81144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2313 Division Av St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Diggs

(Residence in Baltimore: No. 2313 Division Av St.; yrs. 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): single

6-DATE OF BIRTH: Jan 31 (Month) (Day) 1923 (Year)

7-AGE: ✓ yrs. 10 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS:

10-NAME OF FATHER: James Diggs

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Coates

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Dorsey

(Address) 2313 Division Av.

15.

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

NOV 26 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. 23 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) neo Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy (Coroner)

Nov. 23 1923 (Address) 2502 Edmondson Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peter's Cem — DATE OF BURIAL: Nov. 26th 1923

20-UNDERTAKER: Joseph A Farrell — ADDRESS: 2319 Division Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Dup.)

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 81144

100-001 D 81144

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurr a hospital or in tion, give its N instead of street number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Division ST.; WARD)

2-FULL NAME Mary Jennette Diggs

(a) RESIDENCE. No. 2313 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and Sta

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs mos

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Digg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Coates.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md.

14 Informant Anna Chase

(Address) 2718 Division St.

15 Filed NOV 26 1923 . 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23

17 I HEREBY CERTIFY, That I attended deceased

nov 19, 1923, to nov 23, 19

that I last saw h alive on nov 20, 19

and that death occurred, on the date stated above, at 5-30 A

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 1

CONTRIBUTORY (Secondary) (duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard L. Farrell M.

11/23, 1923 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent C state (1) Means and Nature of Injury, and (2) whether Accid Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem — DATE OF BU Nov. 2

20 UNDERTAKER Joseph A. Farrell ADDRESS 1319 D

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81145

CERTIFICATE OF DEATH.

x 90 D 81145

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HENRY DUNLOP WILLIAMS

(a) RESIDENCE NO. UNION MEMORIAL HOSPITAL ST., 12 WARD (Buxton, Md.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 13 ds. How long in U. S., if of foreign birth? 70 yrs. 2 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice W. Williams

6 DATE OF BIRTH (month, day, and year) Sept-19-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country) Petersburg, Virginia

PARENTS

10 NAME OF FATHER Jas. Dunlop Williams

11 BIRTHPLACE OF FATHER (city or town) Petersburg (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Williams

13 BIRTHPLACE OF MOTHER (city or town) Petersburg (State or country) Virginia

14 Informant Robt. D. Bartlett (son-in-law) (Address) Buxton, Md.

15 Filed NOV 26 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1923, to Nov. 24, 1923, that I last saw him alive on Nov. 24, 1923, and that death occurred, on the date stated above, at 8:07 P. m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion with myocardial failure.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A B Price M. D.

11/24. 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREEN MOUNT CEMETERY — DATE OF BURIAL: Nov-27-19

20 UNDERTAKER: STEWART & MOWEN COMPANY — ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81146

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1511 Bolton ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Penn Lewis

(a) RESIDENCE NO. 1511 Bolton ST., 14 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? 67 yrs. 2 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Woollen Lewis

6 DATE OF BIRTH (month, day, and year): Sept 2 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney-at-Law

(b) General nature of industry, business, or establishment in which employed (or employer): Law

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm. Penn Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Isabelle J. MacFarren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Mary W Lewis (wife)

(Address) 1511 Bolton St.

15 Filed NOV 26 1923, 19 ROBERT J. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23d 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1923, to Nov 23d, 1923, that I last saw h— alive on Nov 23d, 1923 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute urinary suppression following vesical instrumentation (Uraemia)

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Carcinomatous degeneration of Vesicle Papilloma (duration Some yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Cystoscopy Date of Nov 19th

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) E. L. Edmunds M. D.

11/24, 1923 (Address) 1515 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY — ADDRESS: 108 W. NORTH AVE.

WILLIAM F. MOWEN, Successor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT record. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81147

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Etting ST. 17 WARD)

2-FULL NAME George H. LeCato

(a) RESIDENCE NO. 1325 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha LeCato

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) 0&0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER George H. LeCato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Hatter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Venus Atkinson

(Address) 1370 Scott Street

15 Filed NOV 28 1923, 19

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1923, to Nov 23, 1923, that I last saw him alive on Nov 23 1923, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Edward Fisher, M. D.

11-24-1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery | DATE OF BURIAL: Nov 27 1923

20 UNDERTAKER: Chris T. Johnson | ADDRESS: 716 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81148

1-001

D 81148

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2011 Jefferson st ST., 6 WARD)

2-FULL NAME Robert Lee Burns

(a) RESIDENCE NO. 2011 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8-1913

7 AGE: 10 Years 6 Months 16 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Walter S. Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Anna M. McKinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Walter L. Burns

(Address) 2011 Jefferson st

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11—24 1923

17 I HEREBY CERTIFY, That I attended deceased from 11—15 1923, to 11—24 1923,

that I last saw him alive on 11—24 1923,

and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) — yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Recurrent

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah C. Russell, M. D.

, 19 (Address) 15 N Milton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: Wm C. Miller — ADDRESS: 2334 Jefferson st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81149

CERTIFICATE OF DEATH.

117 D 81149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chris E. Goldbeck

(a) RESIDENCE NO. 2322 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Early and correct information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine R Goldbeck

6 DATE OF BIRTH (month, day, and year) Sept 13-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Goldbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Sophie Goldbeck (Address) 2322 Jefferson St

15 Filed NOV 26 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923, to Nov. 25, 1923, that I last saw him alive on Nov. 25, 1923, and that death occurred, on the date stated above, at 9 20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured appendix - post operative pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 16, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dybert, M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Nov 29 1923
20 UNDERTAKER	ADDRESS
Geo E. Miller	253 Jefferson St

Spec.—1-10-21—M&T—1500 Blks.

D 81150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 81150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 768 W. Mulberry ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Atkinson

(a) RESIDENCE NO. 768 W. Mulberry ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1, 1923

7 AGE — Years: — Months: 4 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: W. Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co Va

12 MAIDEN NAME OF MOTHER: Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Point Va

14 Informant (Address): Wm Atkinson 768 W Mulberry

15 Filed NOV 26 1923 19..... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 23 1923 to Nov 24 1923.

that I last saw h alive on Nov 24 1923,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Hould M.D.

11/26/23 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 11/26 1923

20 UNDERTAKER: Jas F. Shinnick ADDRESS: 1620 E. Mad. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81151

CERTIFICATE OF DEATH.

129 D 81151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Hollins ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Washington Seward

(a) RESIDENCE NO. 1211 Hollins ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Laura R. Clanahan

6 DATE OF BIRTH (month, day, and year) July 12-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butter-Egg dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) White Plains- Virginia (State or country)

PARENTS

10 NAME OF FATHER Mr. Seward

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Laura R. Seward

(Address) 1211 Hollins Street

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

NOV 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1923 to Nov 23, 1923, that I last saw h[illegible] alive on Nov 22, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P. E. & Lab.

(Signed) Homer L. Todd, M. D.

11/23 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Nov. 26 1923

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 N. Eutaw

D 81152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81152

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Union Memorial Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Ida B. Makinson

(Residence in Baltimore: No. 1028 W. Fayette St. St.; yrs. 54 mos. 0 ds. 12

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. November (Month) 10 (Day) 1869 (Year)

7-AGE. 54 yrs. 0 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Wolfenden

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth Maxwell

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Robert E. Makinson

(Address) 1028 W. Fayette St.

15-

Filed ..... 192.... Registrar.

NOV 26 1923 ROBERT R. KRESS, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 22 (Day) 192.3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemia

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)

11-23 192.3 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos. 1 ds. In the State. 54 yrs. 0 mos. 12 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1028 W. Fayette St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Nov 24 1923
20-UNDERTAKER. Cary & Root	ADDRESS 103 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 81153

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 St Paul St ST., 11 WARD)

2-FULL NAME Joseph Packard

(a) RESIDENCE NO. 806 St Paul St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Nota Packard

6 DATE OF BIRTH (month, day, and year) April 10th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Joseph Packard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER Rosina Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pittsburgh Pa.

14 Informant (Address): Mrs Joseph Packard 806 St Paul St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1923, to Nov 24th, 1923,

that I last saw h[illegible] alive on November 23d, 1923,

and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

~~Angina Pectoris (Coronary Disease)~~

Arterio-sclerosis

CONTRIBUTORY (Secondary) ~~Arterio~~ Angina Pectoris (duration) yrs mos ds.

diabetes mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F. Lockwood, M. D.

11-24-1923 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Belmont Cemetery	Nov 26 1923
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son Co	Oakland Md

Spec.—1-10-21—M&T—1500 Blks.

D 81154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 81154

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 ST., 3 WARD)

2-FULL NAME Roland Glascoe

(a) RESIDENCE NO. 26 S Bethel ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer 086

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant
(Address)

15 Filed ....., 19.... ROBERT R. KRAUTER Registrar
Burial Permit Clerk
NOV 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 / 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....

that I last saw h... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Nov 27 1923

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

81155

HEALTH DEPARTMENT—CITY OF BALTIMORE D 81155

101-061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watson

(a) RESIDENCE NO. 613 W. Lee St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Martha Frazer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed NOV 26 1923 Registrar ROBERT R. KRAMER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from November 14 1923, to November 22 1923, that I last saw him alive on November 22, 1923, and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Abscess of Lung (Post Pneumonia)

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Clark G Brown M. D.

11-22 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
McCourtee	11/24/1923
20 UNDERTAKER	ADDRESS
Uriah L Brown & Son	1811 Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Howell B Hoffmaster

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81156

188 D 81156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

D 81156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13 WARD)

2-FULL NAME Howel. B. Hoffmaster

(a) RESIDENCE NO. 713 W. 34th st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura A Hoffmaster

6 DATE OF BIRTH (month, day, and year) Nov 27 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R.R. Co

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Hoffmaster

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hoffmaster

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant H. B. Hoffmaster
(Address) 713 W 34 St

15 NOV 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Shock

(duration) yrs. a few mos. hrs.

CONTRIBUTORY (Secondary) Caught between cars at Mt Clare Shops

(duration) yrs. mos. ds.

(Signed) J. K. Gerstel, M. D.
(Coroner.)

11-24 1923 (Address) 107 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Nov 26 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 2415 CHESTNUT AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81157

11-00 D 81157

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 S. Stricker ST., 19 WARD)

2-FULL NAME David A. Lang

(a) RESIDENCE NO. 100 S. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna I. Lang (Nee Rhine)

6 DATE OF BIRTH (month, day, and year) January 14, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	64	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 0-30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Prudential Cit Co

9 BIRTHPLACE (city or town) ..... (State or country) Scotland

PARENTS

10 NAME OF FATHER ----- Lang

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Scotland

14 Informant Anna I. Lang

(Address) 100 S. Stricker St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1923, to Nov 22, 1923,

that I last saw h in alive on Nov 22, 1923,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe a left lung weak - from which he did not seem to improve -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure after abdominal operation, 2 days

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Burbert. M. D.

Nov. 26/23, 19 (Address) 1100 W Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Olivet Cemetery — DATE OF BURIAL Nov 26, 1923.

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81158

CERTIFICATE OF DEATH.

120 D 81158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Aisquith ST., 10 WARD)

2-FULL NAME Kenneth Leslie Ballou.

(a) RESIDENCE No. 1002 Aisquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State) New York

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 28. 1912

7 AGE — Years: 10 — Months: 11 — Days: — If LESS than 1 day, ...hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS

10 NAME OF FATHER: Leslie H Ballou

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Haven Conn

12 MAIDEN NAME OF MOTHER: Ethelind C Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brooklyn N.Y.

14 Informant: Leslie H Ballou (Address) 1002 Aisquith St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923, to Nov 24, 1923, that I last saw him alive on Nov 24th, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease

about (duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Dropsical effusion affecting Heart

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Waldram, M. D.

, 19 (Address) 210 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Nov 27 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81159

CERTIFICATE OF DEATH.

90 D 81159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Snowden

(a) RESIDENCE NO. 130 W. Preston St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Fannie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Municipal Hospital Records. (Address)

15 Filed NOV 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 10 19 23. to November 23 19 23.

that I last saw her alive on November 22, 19 23,

and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative) Myocardial Insufficiency

(duration) yrs. 1 mos. (Estimated) ds.

CONTRIBUTORY (Secondary) Myocardial Failure

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S Lowe M. D.

11-23-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 11/26 1923

20 UNDERTAKER Samuel Kennedy ADDRESS 528 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81160

100-001

D 81160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. ..... City ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Pasquell

(a) RESIDENCE NO. 218 Norris ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominick Pasquell

6 DATE OF BIRTH (month, day, and year) Oct 27 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	47		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Leo Dafon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Susan Woulf

(Address) 210 E Norris St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov. 23, 1923, that I last saw her alive on Nov 23, 1923 and that death occurred, on the date stated above, at 6.07 P m.

The CAUSE OF DEATH* was as follows:

Aspiration pneumonia following extraction of teeth.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Lung abscess (duration) yrs. ~~11~~ mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Nov. 23, 1923

Was there an autopsy? No operated entire for abscess

What test confirmed diagnosis? Physical exam. & X-ray

(Signed) G. T. [illegible] M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Md — DATE OF BURIAL Nov 27 1923

20 UNDERTAKER John J Fields — ADDRESS 1200 N Lombard

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81161

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 Harvey St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael antlitz

(a) Residence No. 707 Harvey St., Ward

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy antlitz.

6-DATE OF BIRTH (month, day and year): July 8 1875

7-AGE: 48 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John. antlitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Annie Smith.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Lucy antlitz

(Address): 707 Harvey St

15- Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 24. 1923.

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922 to Nov 24 1923

that I last saw him alive on Nov 24 23

and that death occurred, on the date stated above, at 5-45-P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. 24 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1305 Linden St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens M. D

11/26 1923 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lowertz Cem. DATE OF BURIAL, 11-27 1923

20-UNDERTAKER: E & B Hahn ADDRESS 1156 W Lex St

N. B.—ALL BLANKS must be carefully filled. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81162

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D 81162

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. 4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Owens

(a) RESIDENCE NO. 641 Rabory St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Later information gives date birth July 23-1879 mo)

6 DATE OF BIRTH (month, day, and year) ?

7 AGE (44) Years | Months | Days | If LESS than 1 day, hrs or min.

~~44 5~~ ?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing 069

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Record

(Address) Johns Hopkins Hosp

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 22, 1923.

that I last saw h[illegible] alive on Nov 22, 1923.

and that death occurred, on the date stated above, at 7-15 m.

The CAUSE OF DEATH* was as follows:

Cerabral haemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Robert Wilson M. D.

, 19 (Address) Johns Hop Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn ct — DATE OF BURIAL: Nov 26 1923

20 UNDERTAKER: C. H. Brownson — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

M 802 10M 10-9 23

THE JOHNS HOPKINS HOSPITAL

WINFORD H. SMITH, M. D., DIRECTOR

FIELD T. LONGCOPE, M. D.
PHYSICIAN-IN-CHIEF

N M. T. FINNEY, M. D.
SURGEON-IN-CHIEF

HITRIDGE WILLIAMS, M. D.
OBSTETRICIAN-IN CHIEF

JOHN HOWLAND, M. D.
PEDIATRICIAN-IN-CHIEF

ADOLF MEYER, M. D.
PSYCHIATRIST-IN-CHIEF

WILLIAM G. MACCALLUM, M. D.
PATHOLOGIST

November 26, 1923.

Bureau of Vital Statistics,
Health Department,
Baltimore, Md.

Gentlemen:

On the undertaker's certificate for Fannie Owens, 641 Raborg Street, Baltimore, who died at the Johns Hopkins Hospital on November 22nd, 1923, we have made a correction in the age, as we found from better information that she was born July 23, 1879. You will note on the original certificate the age was 59 with a question mark after it. The correct age is 44.

Very truly yours,

WJC:MM

Walter J. Craig, M. D.,
Assistant Director.

Spec.—1-10-21—M&T—1500 Blks.

D 81163 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 81163

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 Benefit ST. 76 WARD)

2-FULL NAME Ernst C. Schroeder

(a) RESIDENCE NO. 3715 Benefit ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Brummel

6 DATE OF BIRTH (month, day, and year): Apr 27 - 1858

7 AGE: Years 65 Months 6 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Gustav Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Bertha Schroeder

(Address) 3715 Benefit St

15 Filed NOV 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 31, 1923, to Nov. 24, 1923, that I last saw h[is] alive on Nov. 23, 1923, and that death occurred, on the date stated above, at 9 17 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis.

from History

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis.

(duration) yrs. 4 weeks mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of none.

Was there an autopsy? No.

What test confirmed diagnosis? Sputum - Typical Report.

(Signed) W. C. McClanahan M. D.

(Address) 3501 Dan X St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem

DATE OF BURIAL: Nov. 27 1923

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Aliceanna

Cor.—1-12-23—M&T—100 Blks.

D 81164 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 81164

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Edward St ST., 5 WARD)

2-FULL NAME Melville Epps

(a) RESIDENCE NO 1222 Edward St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 1st/23

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dewey Epps

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Margaret Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Margaret Epps
(Address) 1222 Edward St.

15 Filed NOV 26 1923 192 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 4 or 1 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Waters, M. D.
(Coroner.)

Nov 26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov 14 1923

20 UNDERTAKER Mrs. R. D. Elliott — ADDRESS 1712 Eastern Ave.

IMPORTANT—Information should be carefully supplied. Note should be taken that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81165 ✓ D 81165

CERTIFICATE OF DEATH.

188-000

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Bay View Hospital 26 ST., ... WARD)

2-FULL NAME John E. Bell

(a) RESIDENCE NO. 817 So - 3rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 9th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Crane operater
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Charles Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Selma A. Ritter
(Address) 817 So. 3rd St

15 Date NOV 26 1923 192 Registrar Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken Neck

(duration) yrs. mos. ds. at once

CONTRIBUTORY (Secondary) Auto Accident -

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.
(Coroner)

, 192 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional data.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL: Nov. 28 1923

20 UNDERTAKER: Zickler & Zickler — ADDRESS: 1739 E. Eager

NOV 26 1923

INFORMATION should be carefully supplied. AGE, PLACE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81166

CERTIFICATE OF DEATH.

170 D 81166

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Fleet ST., 3 WARD)

2-FULL NAME Joseph Kleszczewski

(a) RESIDENCE NO. 1521 Fleet ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 16 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Kleszczewski

6 DATE OF BIRTH (month, day, and year) March 20/1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Near beer Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Louis Kleszczewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Julia Kleszczewski 1521 Fleet St

15 Date NOV 26 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH* was as follows: Hemorrhage Brain Suicide - Shot Self through head

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner)
Nov. 26 1923 (Address) Curtis Bay, Balto Co Md

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Nov 28 1923
20 UNDERTAKER	ADDRESS
John H Weber	603 Bank St

NOV 26 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81167

100-001

D 81167

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4852 Park Heights ave ST., 7th WARD)

2-FULL NAME Salvatore Citrano

(a) RESIDENCE No. 4852 Park Heights ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 29-1922

7 AGE — Years: — Months: 11 Days: 27 If LESS than 1 day, hrs. or min.: ....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Vincenzo Citrano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosaria Pitarro

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Vincenzo Citrano 4852 Park Heights ave

15 Filed: NOV 26 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-26 1923.

17 I HEREBY CERTIFY, That I attended deceased from 11-2-, 1923, to 11-26, 1923 that I last saw him alive on 11-25, 1923 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia -

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) S. Debenedetto, M. D.

(Address) 1604 Linden ave 11-26 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Nov. 28 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Hanford ave

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

(Arthur)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81168

CERTIFICATE OF DEATH.

D 81168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3rd Ave. Ext. St., 76 WARD)

REGISTERED No. C Purnell 1002 ✓

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Arthur

(Residence in Baltimore: No. 3rd Ave. Ext. St., 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 25, 1869
(Month) (Day) (Year)

7-AGE, 54 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Arthur

(Address) 3 Ave Fairfield

15-

Filed ..., 191...

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 26 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1923
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov. 15 1923, to Nov. 25 1923, that I saw h[illegible] alive on 11/25 1923, and that death occurred, on the date stated above, at 2.00 m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. 6 mos. ds.

(Signed) [illegible] M. D.

Nov 27, 1923 (Address) 1340 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Int Auburn Cem. DATE OF BURIAL, 11-27, 1923

20-UNDERTAKER George T. A. Gilson ADDRESS 1335 Druid Hill Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81169

CERTIFICATE OF DEATH.

70 D 81169

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1371 N. Strieker St. (St.:) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Brogden

(a) RESIDENCE. No. 1371 N. Strieker St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD, and item ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 26 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ — Gertrude Brogden

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, day

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Brogden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Nannie Sears.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Gertrude Brogden (Address) 1351 N. Strieker

15 Filed ... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 19 , to Nov. 23, 19 , that I last saw h... alive on Nov. 23, 19 , and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Ascess of brain.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation only.

(Signed) Edward E. Brogden M. D.

19 (Address) 115 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Nov 27th 19

20 UNDERTAKER: A. Jones ADDRESS: 111 S. Gilmor St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81170 CERTIFICATE OF DEATH. D 81170

38

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. 21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas Berger

(a) RESIDENCE NO. 1026 Denver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Bodie Berger

6 DATE OF BIRTH (month, day, and year) last course 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Window Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert M. Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Florence Ayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Bayview Hospital Balto, Md.

Filed NOV 26 1923, 19 Robert P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923, to Nov. 26, 1923, that I last saw h[illegible] alive on Nov. 25, 1923 and that death occurred, on the date stated above, at 4:09 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

Luetic Conjecture (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Goldwasser, M. D.

1923 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/28 1923

20 UNDERTAKER W. D. Cook

ADDRESS 502 E. North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81171

113 D 81171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1803 St Paul St

CITY OF BALTIMORE: (No. 1803 ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Lee Rennix

(a) RESIDENCE NO. 1803 St Paul St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1, 1923

7 AGE — Years [redacted] Months 1 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER C. D. Rennix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Bateman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pattsburg

14 Informant C. D. Rennix

(Address) 1803 St Paul St

15 Filed NOV 26 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 – 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov-24, 1923, to Nov-26, 1923,

that I last saw her alive on Nov-25th 1923

and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Intoxication Intestinal

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Malnutrition and Chronic Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles Irving Jobin, M. D.

, 19 (Address) 1017 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Nov. 26, 1923 DATE OF BURIAL 19

20 UNDERTAKER: Wm Cook ADDRESS 502 East Nat'l ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81172

D 81172

CERTIFICATE OF DEATH.

X 188-023

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Streett

(a) RESIDENCE NO Parkton Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie (Baker) Streett

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R.R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penn. R.R

9 BIRTHPLACE (city or town) (State or country) Balto. CO. Md.

PARENTS

10 NAME OF FATHER William Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Jennie Streett
(Address) Parkton Md.

15 Filed ..... 192 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-(Occiput & Base)

Automobile Accident-Inquest to held Nov.28/23)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Waller, M. D.
(Coroner.)

Nov 26/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stablers Cemetery — DATE OF BURIAL Nov 28 1923

20 UNDERTAKER J. Marlene & Sons. — ADDRESS White Hall Md

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81173

CERTIFICATE OF DEATH.

146 D 81173

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Beech St. (WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Agnes Tipton

(Residence in Baltimore: No. 1840 Beech St.; St.; 18 yrs., 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	White	Married

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1905 (Year)

7-AGE,	If LESS than 1 day,
18 yrs. 1 mos. 19 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Geo. Link

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Carrie Gerbeck

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Link

(Address) 1846 Beech St.

15- NOV 28 1923

Filed....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day), 191... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1923, to Nov. 25 1923, that I saw h-er alive on 11, 25 1923, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Circulation

18 hours (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Anemia

8 hours (Duration) ....yrs. ....mos. ....ds.

(Signed) L. J. Hirschhorn M. D.

11.26., 1923 (Address) 1826 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Nov. 29.., 1923

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

D 81174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81174

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Catonsville near Frederick St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Murray

(Residence in Baltimore: No. Catonsville St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: Unknown Years About 60 Mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: John Murray

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine Smith

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. Ruby

(Address) 605 Woodbridge St

15-

Nov 26 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and ....., find that said deceased came to ..... death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrissey M. D. (Coroner.)

Nov 24 1923 (Address) 2532 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: 11-27-1923

20-UNDERTAKER: H. C. Brauning Son — ADDRESS 517 N. Schroeder St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81175

D 81175

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 Emerson ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Rolls

(a) RESIDENCE. No. 2514 Emerson ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rolls

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Roanoke City Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) James T. Drilling Son 2514 Emerson St.

15 Filed . 19 Robert P. Harrison Registrar

NOV 26 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 . 1923, to Nov 26th 1923.

that I last saw he alive on Nov 24 . 1923,

and that death occurred, on the date stated above, at 1220 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of +

Was there an autopsy? no

What test confirmed diagnosis? Dam.

(Signed) U Ker Williams M. D.

, 19 (Address) 601 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 28 1923

20 UNDERTAKER Easton Sons — ADDRESS Elliott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81176

CERTIFICATE OF DEATH.

D 81176

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of the Poor 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wheatley

(a) Residence No. Preston Talbot Co., St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single Wheatley

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE About 82 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Wm Wheatley

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER, Sally Murray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

11- (Informant) Sister Sisters of the Poor

(Address) Preston Talbot Co.

15- Filed NOV 26 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/26/23

17- I HEREBY CERTIFY, That I attended deceased from 11/20 1923 to 11-25 1923

that I last saw h. alive on 11-25 1923

and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Bernard Wiltz M. D

11/26 1923 (Address) 9.4 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Paul's Cem. DATE OF BURIAL. Nov. 28 1923

20-UNDERTAKER. Easton Sons ADDRESS Ellicott City

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

(Prizginas)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81177

CERTIFICATE OF DEATH.

X 101-001

D 81177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3145 10th St., 7th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Prizginas

(a) RESIDENCE NO. 3145 10th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 20/1920

7 AGE: Years 3 Months 9 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Laurel (Md.)

PARENTS

10 NAME OF FATHER: Mike Prizginas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Thomas Pondylas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: Mike Prizginas

(Address)

15 Filed NOV 26 1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Nov 20, 1923, that I last saw h[illegible] alive on Nov 25, 1923, and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Strahl, M. D.

, 19 (Address) 500 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: 11/27/1923

20 UNDERTAKER: Geo. J. Tully

ADDRESS: 1735 Harford.

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81178 ✓

D 81178

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Charles B. Tavern

(a) RESIDENCE NO. Danville, Va ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Feb 23-1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	13	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Charles Tavern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Bertha Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Johns Hopkins Hospital (Address)

15 Date NOV 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923, to Nov 26, 1923, that I last saw him alive on Nov. 26, 1923, and that death occurred, on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Brain tumor - glioma

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? Yes Date of 11-23-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield McPherson, M. D.

, 19 (Address) Hutt 11-26-23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Pa — DATE OF BURIAL Nov 26 1923

20 UNDERTAKER Joseph Abrens — ADDRESS 221 Bway

NOV 26 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant

Spec. 3-10-21 MAT 1500 B

D 81179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Sleeth

(a) RESIDENCE NO. Parsons W. Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thelma Sleeth

6 DATE OF BIRTH (month, day, and year) May 14 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Jim Sleeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Johns Hopkins Hospital

15 Filed NOV 26 1923 [illegible Harrison] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Nov 26, 1923,

that I last saw him alive on Nov. 26, 1923,

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

Myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Post operative shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 26 '23

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) J. L. Reichert M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PARSONS W.VA

DATE OF BURIAL 10-26-23

20 UNDERTAKER H. E. Hughes

ADDRESS 4th & Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. [illegible] copy of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

DV 26 1923

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81180

CERTIFICATE OF DEATH.

D 81180

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W. York St. ST. 22 WARD)

2-FULL NAME Henrietta Kemmer. (C)

(a) RESIDENCE No 112 W. York St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Widow.

5a If married, widowed, or divorced
(of) WIFE of Willian Kemmer (C)

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Annie Fowler (C) niece.
(Address) 742 W. Mulberry St.

15 NOV 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.
Oedema of the Lungs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov, 25, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 27 192

20 UNDERTAKER John H. Toadvine — ADDRESS 412 N. Eutaw St

Manner should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81181 164 D 81181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Cherry ST. Curtis Bay, Balto. Md WARD 25)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wincent Zaruba

(a) RESIDENCE. No. 206 Cherry ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 16th 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Vader Zaruba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Jos Zaruba (Address) 206 Cherry St

15 Filed NOV 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22nd, 1923, to Nov 24th, 1923

that I last saw h in alive on Nov 22nd 1923

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Old age & General Debility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos B. Horton, M. D.

(1923 Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Nov 26 1923
20 UNDERTAKER	ADDRESS
Fred Eversdorf	Curtis Bay, Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Answer all questions so far as information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81182

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 1 WARD)

2-FULL NAME Edwin Kuss

(a) RESIDENCE NO. 735 So. Linwood av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lithographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer A Thompson Co

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Kuss

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Mahle

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Minnie Kuss
(Address) 735 So. Linwood Ave

15 Filed NOV 27 1923 Registrar

ROBERT R. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
(duration) about yrs. mos. ds.
CONTRIBUTORY (Secondary) Auto Accident (duration) yrs. mos. ds.

(Signed) Thos. Horton M. D.
(Coroner.)
Nov 26th 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 29 1923
20 UNDERTAKER	ADDRESS
H. Sander's Sons	1110 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1924
45

HEALTH DEPARTMENT—CITY OF BALTIMORE

Retired

D 81183

CERTIFICATE OF DEATH.

460

D 81183

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 N. Bath St. ST. 20th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Frances Schaub

(a) RESIDENCE NO. 2809 N. Bath St. ST. 20th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. Schaub.

6 DATE OF BIRTH (month, day, and year) Jan 1st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Frank

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Stapp

13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country) Md

14 Informant Fred Schaub Sr (Address) 2809 N. Bath St

15 Filed NOV 27 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Nov 25, 1923.

that I last saw h[illegible] alive on Nov 24, 1923,

and that death occurred, on the date stated above, at 6 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and Intestines

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary Oedema (duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of

Was there an autopsy?.....

What test confirmed diagnosis?

(Signed) Robert C. Hirst M. D.

11/26 1923 (Address) 2157 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov 1924

20 UNDERTAKER J. B. Stappert — ADDRESS 2236 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81184

188-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick M. Sporrer

(a) RESIDENCE No 517 Orkney Ave., Govans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lida E. Sporrer

6 DATE OF BIRTH (month, day, and year) October 25/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	1	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Supt. Burgarly Dept.
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. F & G Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Matthew Sporrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Thomas Sporrer
(Address) 29th & Fenwick Ave.

15 NOV 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Granted

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- Intercranial Hemorrhage
Automobile Accident

(Inquest to be held Nov 28/23

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. T. Ballen M. D.
(Coroner)

Nov 26/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Hope

DATE OF BURIAL Nov 28 1923

20 UNDERTAKER Wm. H. off Reedmer

ADDRESS 1301 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81185

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Pronounced dead at Johns Hopkins Hospitad ST., 27 (WARD)

2-FULL NAME Lida E. Sporrer

(a) RESIDENCE NO 517 Orkney Ave. Govans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick M. Sporrer

6 DATE OF BIRTH (month, day, and year) Feb. 28/1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Household 03
(b) General nature of industry, business, or establishment in which employed (or employer) At home.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benjamin W. Ady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Thomas Sporrer
(Address) 29th St. & Fenwick Ave.

15 Filed NOV 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Granted

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- Intercranial Hem.
Automobile Accident
(Autopsy to be held Nov. 28/23)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pocock (Coroner.) M. D.

Nov 26 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 28 1923

20 UNDERTAKER Henry Hoeck & Sons — ADDRESS 1901 Eastern Ave

BURIAL SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE VERY PARTICULAR IN STATING THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81186

CERTIFICATE OF DEATH.

90 D 81186

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Presstman ST., 15 WARD)

2-FULL NAME Robt. Harris

(a) RESIDENCE No 1504 Presstman St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arlena Harris

6 DATE OF BIRTH (month, day, and year) about 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 75 yrs				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unemployed
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lillian Hall
(Address) 1504 Presstman St.

15 Filed NOV 27 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) no testing

(duration) yrs. mos. ds.

(Signed) J. E. Hennessy, M. D.
(Coroner)
Nov. 25, 1923 (Address) 2 S. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., In the State ... yrs., ... mos., ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL 11/27 1923

20 UNDERTAKER James A. Dennis

ADDRESS 1303 Presstman

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81187

CERTIFICATE OF DEATH.

90

D 81187

1-PLACE OF DEATH Hudson Heights

CITY OF BALTIMORE: (No. Patapsco St near Fait Ave ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Schmitd

(a) RESIDENCE NO. Patapsco St near Fait Ave ST., 26 WARD Hudson Heights

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmitd

6 DATE OF BIRTH (month, day, and year) March 10th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Dairyman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Adam Schmitd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Schmitd

(Address) Patapsco St near Fait ave

15 Filed NOV 27 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1909 to Nov 24 1923

that I last saw h alive on Nov 24 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 14 yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Burke, M. D.

1923 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery — DATE OF BURIAL Nov. 27th 1923

20 UNDERTAKER Lilly & Geiler — ADDRESS 4032 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 81188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2931 Huntingdon Ave (Ward) 16

2-FULL NAME Marie E Harrington

(a) RESIDENCE NO. 2931 Huntingdon Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Harrington

6 DATE OF BIRTH (month, day, and year) Apl 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	56	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry McEwen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles Spann

(Address) 2631 Huntingdon

15 Filed NOV 27 1923 R. KRAMER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Nov 26, 1923,

that I last saw h alive on Nov 25, 1923

and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis —

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H B Normand, M. D.

Nov 27, 1923 (Address) 3347 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 28 1923

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81189 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 81189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Forrest & Lexington St., 5th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Heath — Forrest T Lexington

(a) RESIDENCE NO (Usual place of abode) St., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertie Heath

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab. Gen
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John W. Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mckeon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertie Heath (Address) 117 Thames

15 Filed NOV 27 1923 192 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure due to Valv. Disease of Heart.

as a result of Phthisis Pulmonalis mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

, 192 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 27 1923
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1725 Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK. ENTRY of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 81190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Exeter ST., 5 WARD)

2-FULL NAME Robert V Bryan

(a) RESIDENCE NO 19 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Bryan

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	41 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gard. Lab
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ely. Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Cecelia Bryan
(Address) 19 N Exeter

15 Filed ...192... Registrar

NOV 27 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pt was had sum month may have been Pulmonary may have been Tbc arrhythmia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bedridden (duration) yrs. mos. ds. no history of cough

(Signed) W. J. Ruby, M. D.
(Coroner)
Nov 27, 1923 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Nov 27 1923
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1726 Eutaw

INSTRUCTIONS: WRITE PLAINLY, WITH UNFADING INK. This certificate is required by law to be filed with the Registrar of Vital Statistics. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81191

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 145 Arlington St., 18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Zaccari.

(a) RESIDENCE NO. 145 Arlington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11 1923

7 AGE: Years — Months 8 — Days 15 — If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Zaccari

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Donnica Marsigli 11-27-1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Frank Zaccari 145 Arlington St.

15 Filed NOV 27 1923 Registrar ROBERT R. KINSTAN Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-25- 1923 to 11-26 1923

that I last saw him alive on 11-26 1923

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

acut cerebrospinal meningitis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acute Cerebrospinal meningitis. (duration) ...yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 11-25-23 [+ serum given

Was there an autopsy? no

What test confirmed diagnosis? Spinal puncture.

(Signed) S. Dudarcz M. D.

(Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Vincent

DATE OF BURIAL 11/28/23

20 UNDERTAKER Frank V. Peterson

ADDRESS 1500 E 32nd St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

45 c.c. fluid removed by spinal puncture 20 c.c. meningococcus serum from health department given & this dose repeated.

Epidemic J. Doe

Spec—12-23-21—E.B.R.S.—400 Lks.

D 81192 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81192

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1110 Linden ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Levi

(a) Residence No. 1110 Linden Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Harris Levi

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 46 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER: Yehuda Leib Sachs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER: Dora Katz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-(Informant) Harris Levy

(Address) 1110 Linden ave

15-Filed NOV 27 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/27/23

17- I HEREBY CERTIFY, That I attended deceased from 1920, 19..., to Nov 26th, 1923, that I last saw h alive on Nov 26th, 1923, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Fabian M. D.

, 19 (Address) 211 N Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Adrian Northern ave — DATE OF BURIAL. Nov. 26 1923

20-UNDERTAKER. Jacob Lewis — ADDRESS 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-17-23—M&T—100 Bks.

81193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81193

REGISTERED NO. 187

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13 WARD)

2-FULL NAME Teodor Sanchinovitz

(a) RESIDENCE No. 25-29 Francis ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Samsonovitz

6 DATE OF BIRTH (month, day, and year) Sept 14-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	2	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rucker—Oil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed NOV 27 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Crushed Chest a Few Hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Caught in Elevator
(duration) yrs. mos. ds.

(Signed) N K Fonseca, M. D.
(Coroner.)

11-26 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew North Point Cemetery DATE OF BURIAL 11/27 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 81194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81194

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Riverside Ave St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan alice Schenkel

(a) Residence No. 1000 Riverside Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Thomas Schenkel

6-DATE OF BIRTH (month, day and year) Sept 7 1853

7-AGE. 70 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Basil Reston

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Elyabeth Bradley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Thomas Schenkel

(Address) 1000 Riverside Ave

NOV 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from about 1 year, 19.... to Nov. 26, 1923 that I last saw h.. alive on Nov. 26 1923 and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

about 4-5 hours (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation Heart ? 2 years or more

(Duration) ? yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) G. Latrobe Ewell M. D

11/26, 1923 (Address) 2945 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL, Nov. 28 1923

20-UNDERTAKER, John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81195

CERTIFICATE OF DEATH.

90 D 81195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N. Milton ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Combs

(a) RESIDENCE. No. 818 N. Milton ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Combs

6 DATE OF BIRTH (month, day, and year) Sept 20 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H. Foudel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. W. Combs (Address) 818 N. Milton ave

15 Filed NOV 27 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 19 23, to Nov 26, 19 23, that I last saw him alive on Nov 25, 19 23, and that death occurred, on the date stated above, at 8 15 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chron Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Sept 30/23 HERNIA

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) Chas F Lemmon M. D.

11/27, 19 23 (Address) 7181 Fulton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Nov 29th 1923

20 UNDERTAKER Geo Leimbach & Son ADDRESS 647 W. Pratt St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81196

CERTIFICATE OF DEATH.

D 81196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 612 Gold St.: 15 WARD)

2-FULL NAME John Mosely

(a) RESIDENCE: NO. 612 Gold ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lilly Mosely.

6 DATE OF BIRTH (month, day, and year): April 17. 1863

7 AGE: Years 60 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Jonston's
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wilmington N.C

PARENTS

10 NAME OF FATHER: Frederick Mosely

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): Lilly Mosely 612 Gold St

15 Filed NOV 27 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov 24, 1923, that I last saw h— alive on Nov 23, 1923, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1d ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis.

(duration) yrs. 6? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Wright, M. D.

(Address) 1209 Pitcher Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 27 1923
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81197

CERTIFICATE OF DEATH.

D 81197

REGISTERED NO. 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 518 S Lawrence ST. 7 WARD)

2-FULL NAME Nathan Alfin Warfield

(a) RESIDENCE NO. 518 S Lawrence ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 22. 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Stanley Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Margaret Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant (Address) Mrs Stanley Warfield

15 Filed NOV 27 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Nov 24 1923.

that I last saw h... alive on Nov 24 1923

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

from Unknown

Weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Kelly M. D.

(Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEM

DATE OF BURIAL 11/28 1923

20 UNDERTAKER ROBERT BROOKS AND SON

ADDRESS COR CALHOUN & HOLLINS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81198

CERTIFICATE OF DEATH.

49 ✓

Registered No. D 81198

1-PLACE OF DEATH

City of BALTIMORE: (No. 1319 E. Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Drobis

(a) Residence No. 1319 E Lombard St, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Slata Drobis

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 70 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Hebrew Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Teacher

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-

(Informant): Jack Levis

(Address): 1439 E Baltimore St

15-

Filed NOV 27 1923 ROBERT R. KRAUTH, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-26-23

17- I HEREBY CERTIFY, That I attended deceased from Nov-12, 1923 to Nov-26, 1923

that I last saw him alive on Nov-26, 1923

and that death occurred, on the date stated above, at 8 P M

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate, with metastasis in Liver

(Duration) yrs 3-4 mos. ds

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none

(Signed) Herman Seidel M. D.

11-27-1923 (Address) 2404 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew North Point

DATE OF BURIAL: 11/27 1923

20-UNDERTAKER: German Hill ADDRESS: Jack Levis 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81199

D 81199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 S. Scott St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian A. Hoffman

(a) RESIDENCE. NO. 345 S. Scott St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie E. Merson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant John E. Hoffman
(Address) 345 S. Scott St.

15 Filed NOV 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Nov. 24, 1923, that I last saw h-r alive on Nov. 24, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Manley Strong, M. D.

11-26 23 (Address) 729 Eutaw Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Nov 28 23 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Fulton

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81200

CERTIFICATE OF DEATH.

1729 D 81200

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO 142 N. Lanvale ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Benjamin Franklin Clarkson

(a) RESIDENCE. NO. 142 N. Lanvale ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. — mos. ✓ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Laura J. Clarkson

6 DATE OF BIRTH (month, day, and year) Jany 19—1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman M E Church

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

018

9 BIRTHPLACE (city or town) (State or country) Cassville Pennsylvania

PARENTS

10 NAME OF FATHER David Clarkson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germantown Penna

12 MAIDEN NAME OF MOTHER Elenor Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Huntingdon Co. Penna

14 Informant Charles L Clarkson (Address) 5221 York Rd

15 Filed NOV 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1921, to Nov 26, 1923, that I last saw him alive on Nov 25, 1923, and that death occurred, on the date stated above, at 8.35 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George E. Shannon M. D.

11/27 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Nov 28 23

20 UNDERTAKER: A B Cook — ADDRESS: 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81201

CERTIFICATE OF DEATH.

90 D 81201

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Johnson

(a) RESIDENCE No. 1229 St.James St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Tobbstown Md. (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Louise Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed , 19 Registrar

NOV 27 1923 ROBERT R. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 20, 1923 to November 24, 1923, that I last saw him alive on November 23, 1923, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (degenerative)

Myocardial Insufficiency

(duration) yrs. 6 mos (history) ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude C. Howe, M. D.

11/24/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 11/27 1923

20 UNDERTAKER Samuel J. Hemsley ADDRESS 1179 N. Bdwy

Spec.—1-10-21—M&T—1500 Bks.

D 81202

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 81202

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

2-FULL NAME Samuel Ficklin

(a) RESIDENCE NO. 2210 28th St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed NOV 27 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to November 24 1923.

that I last saw h im alive on November 23, 1923,

and that death occurred, on the date stated above, at 4:15 A.M.,

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A. Dixon, M. D.

11-24-23 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11/27/23

20 UNDERTAKER David J. Stansbury

ADDRESS 5[illegible] Belair

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81203 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 81203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Mens Home ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H Lindenman

(a) RESIDENCE NO. 1400 W Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Lindenman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs H W Tilden

(Address) 1400 W Lexington

15 NOV 27 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 19 23

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 19 23, to Nov 24, 19 23,

that I last saw h alive on Nov 24, 19 23

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Organic Dis. Heart

Cerebro Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood M. D.

Nov 25, 19 23 (Address) 739 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Nov 28 1923

20 UNDERTAKER George W Smith — ADDRESS 1532 Holliday

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Jahenczuk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81204

CERTIFICATE OF DEATH.

113 D 81204

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 Elliot St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Jahenczuk

(a) Residence No. 2708 Elliot St., Ward 15

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): June 28 1923

7-AGE: yrs. 4 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS

10-NAME OF FATHER: Andrew Jahenczuk

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Mary Garlewicz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14-

(Informant) Andrew Garlewicz

(Address) 2708 Elliot St.

15-

Filed NOV 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 26 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1923 to Nov. 26 1923

that I last saw him alive on Nov. 26 1923

and that death occurred, on the date stated above, at 8 15 P m

The CAUSE OF DEATH* was as follows:

Cholera Infantum

following Emaciation

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. R. Brownshas M D

11-27 1923 (Address) 3037 O'Donnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Nov 28 1923

20-UNDERTAKER: John F. Weber

ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 81205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-D 81205

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1825 East Baltimore ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Winifred Ryan

(a) RESIDENCE NO. 1825 East Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 72 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy Ryan

6 DATE OF BIRTH (month, day, and year) July 26, 1836

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
87	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) County Wexford
(State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Shortall

11 BIRTHPLACE OF FATHER (city or town) ----
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) ----
(State or country) Ireland

14 Informant Augustine J Ryan
(Address) 1825 East Baltimore

15 Filed NOV 27 1923 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov. 25, 1923.

that I last saw he alive on Nov. 24 1923

and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

I. Senility —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis —

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. J. Foley — M. D.

11/26 19 23 (Address) 622 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Cathedral Cemetery — DATE OF BURIAL: Nov 28 23

20 UNDERTAKER: H. W. Mears & Son — ADDRESS: 805 N Calvert st

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81206

CERTIFICATE OF DEATH.

31

D 81206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 4603 Pilmico Road St. 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma G. Howard

(a) RESIDENCE NO. 4603 Pilmico Rd St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Noah Howard

6 DATE OF BIRTH (month, day, and year): Oct 12 1885

7 AGE: Years 38 Months 1 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Wm C. Kerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Jessa. Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Noah Howard (Address) 4603 Pilmico Rd

15 Filed NOV 27 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 1 .1923. to Nov 27 .1923.

that I last saw he alive on Nov 27 .1923.

and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/27. 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 28 1923

20 UNDERTAKER: A S Marshall — ADDRESS: 353 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81207

101-001 ✓

D 81207

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lode

(a) Residence No. 1817 W. Pratt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benj F. Lode

6-DATE OF BIRTH (month, day and year) Nov. 1853

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS

10-NAME OF FATHER, James Canadan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Mary Whalen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant). Little Sisters of the Poor,

(Address). Preston St. Balto

NOV 27 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-26-23

17- I HEREBY CERTIFY, That I attended deceased from 11-20 19 23, to 11-25 19 23

that I last saw h. S. alive on 11-25 19 23

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds

CONTRIBUTORY (Secondary) Senile Chronic Nephritis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Kleinberg M. D

11-26, 19 23 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem — DATE OF BURIAL. Nov. 28th 1923

20-UNDERTAKER. Geo M. Faulk & Son — ADDRESS 811 N. Wolfe

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81208

CERTIFICATE OF DEATH.

89 D 81208

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Eutaw Place WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Miller

(a) RESIDENCE No. 2418 Eutaw Place ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Jacob Miller

6 DATE OF BIRTH (month, day, and year) Mch. 13, 1849

7 AGE — Years: 74 — Months: 8 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Trukat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Jacob Miller

(Address) 2418 Eutaw Place

15 Filed ....., 19 ..... Registrar

[Robert P. Harrison, illegible]

NOV 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, to Nov. 26, 1923.

that I last saw h[illegible] alive on Nov. 26, 1923

and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Leitz, M. D.

(Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL: 11/29/1923

20 UNDERTAKER: David Sondheim ADDRESS: 1118 W. Mt. Royal Ave.

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-801 ✓ 74-D 81209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Rosedale Ave. ST., 27 WARD)

2-FULL NAME Katherine Rehling

(a) RESIDENCE No. 16 Rosedale Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Wm. Rehling

6 DATE OF BIRTH (month, day, and year) Apr. 27 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Heinlein

11 BIRTHPLACE OF FATHER (city or town) Ger. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant J. Henry Rehling

(Address) 16 Rosedale Ave.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26 1923

17

I HEREBY CERTIFY, That I attended deceased from July 25 , 1923 , to Nov 26 , 1923 ,

that I last saw her alive on Nov 23 , 1923 ,

and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. 4 mos. - ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bannan Hood, M. D.

Nov 27 1923 (Address) 626 N. Johnson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 11/29 1923

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Fay

Spec.—1-10-21—M&T—1500 Bks.

D 81210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 81210

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1859 Eastern Av. (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Kilchenstein

(a) RESIDENCE NO. 2816 Clifton Park Ter. (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 4 mos. 26 How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30-1883

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
40	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Kilchenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant E. J. Kilchenstein (Address)

15 Filed , 19 Robert P. Harrison Registrar

Burial Permit Issued

NOV 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-23

17 I HEREBY CERTIFY, That I attended deceased from 11-24-23 19 , to 11-26- 19 ,

that I last saw h alive on 11-26- 19

and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs mos 2 ds.

CONTRIBUTORY (Secondary) Streptococcal infection

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of 11-26-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Compton, M. D.

, 19 (Address) 1859 Eastern Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 11/29 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81211

CERTIFICATE OF DEATH.

90 D 81211

REGISTERED NO.

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (No.) ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Keene

(a) RESIDENCE NO. 259 S. Robinson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvena Keene

6 DATE OF BIRTH (month, day, and year) June 24, 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
49	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo Keene

11 BIRTHPLACE OF FATHER (city or town) U. S. A. (State or country)

12 MAIDEN NAME OF MOTHER Annie Rogers

13 BIRTHPLACE OF MOTHER (city or town) U. S. A. (State or country)

14 Informant Record (Address) Johns Hopkins Hosp

15 Filed NOV 27 1923 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Nov 26, 1923, that I last saw him alive on Nov 26, 1923, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Rheumatic Myocarditis + Endocarditis

Myocardial Insufficiency

(duration) ? yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. R Harmon, M. D.

11/26, 1923 (Address) Johns Hop Hosp Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 11/28 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nay

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81212

CERTIFICATE OF DEATH.

74 001

D 81212

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 695 Pierce al ST. 17 WARD)

2-FULL NAME Amelia Chew

(a) RESIDENCE NO. 695 Pierce st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	1	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Mr Johnson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Canada

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary E. Chew
(Address)

15 Filed NOV 27 1923, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

..... (duration) ... yrs. 9 hrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (duration) ... yrs. ... mos. ... ds.

(Signed) H. T. Council, M. D.
(Coroner.)

11-27, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 11-28 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ga ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81213

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 McCulloh St., 11 WARD)

2-FULL NAME Addie Dennis

(a) RESIDENCE NO 913 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): About 1868

7 AGE — Years: 55 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

Nov. 25, 1923

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Alice Smith
(Address) 913 McCulloh St.

15 Filed NOV 27 1923 Robert P. Hartlaub Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov. 25, 1923 (Address) 210 Redwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shandon Wh Md | DATE OF BURIAL: 11-28 1923

20 UNDERTAKER: Dan'l Gaylon | ADDRESS 916 Ea ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81214

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Perry

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 27 1923 , 19 Registrar

0901

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1923, to November 24, 1923.

that I last saw her alive on November 24, 1923,

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Senile Detrioration

Chronic Infections

Arthritis (Hypertrophic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Claude E. Jones M. D.

11-27, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 27 1923

20 UNDERTAKER

ADDRESS

Commissioner Health.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81215

100-001 ✓ D 81215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240-N-Bond ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE NO. 240-N-Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19-23

7 AGE Years Months Days: 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Elsworth Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Annie P. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md

14 Informant: Ella Briggs (Aunt)

(Address) 240 N Bond

15 Filed 11-27 1923 Robert P. Harrison, (OQ) Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1923, to 11-26, 1923,

that I last saw her alive on 11-26, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

Uncomplicated.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical Exam

What test confirmed diagnosis? Autopsy

(Signed) Walter D. Jones M. D.

19 (Address) 161 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 27 1923

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on reverse side of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81216

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. N.E. Cor. Aisquith & Jefferson Sts. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Freid

(a) RESIDENCE No. 1161 Low St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Freid

6 DATE OF BIRTH (month, day, and year): Dec. 25/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond, Va.

PARENTS

10 NAME OF FATHER: Anthony Freid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Dollie Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Sarah Freid, 1161 Low St.

Filed NOV 27 1923, 192 Robert P. Harrison, Registrar

0904 THE MORGUE Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insuffiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis-(History of Rheumatism) (duration) yrs. mos. ds.

(Signed) J S H Coleman, M. D. (Coroner.)

Nov. 22/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Nov 22 1923 192

20 UNDERTAKER

ADDRESS

Commissioner Health.

INSTRUCTIONS—PHYSICIANS, UNDERTAKERS AND OTHERS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 81217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81217

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 Greenmount Ave ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. McBride

(a) RESIDENCE NO 1051 Greenmount Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): July 3/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pipe-fitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Thos. E. McBride

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Mary Ann Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Frank Rivhardson (Sister)
(Address): 1051 Greenmount Ave.

15 Filed ..... 192 ..... Registrar

27 1923

Robert P. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

About 2 or 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paten, M. D.
(Coroner.)

Nov 26/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 11/27 1923

20 UNDERTAKER: Sol Linnson & Bro

ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81218 ✓ X 90 D 81218

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 1st WARD)

2-FULL NAME Wm Stone.

(a) RESIDENCE NO. U.S. Marine Hospital No 1 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

14 Informant Self.
(Address)

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

NOV 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to November 26 1923, that I last saw him alive on November 26 1923, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
Pulmonary Oedema,

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Oedema of Lungs

(Signed) M. X. Foster. M. D.

11/26 1923 (Address) U.S. Marine Hospital No 1 Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 11 27 1923

20 UNDERTAKER Sol. Levinson & Bro

ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81219

CERTIFICATE OF DEATH.

84 D 81219

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp ST., 9 WARD)

2-FULL NAME Baby girl Kelly

(a) RESIDENCE NO. 1913 Homewood Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/18/23

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		9 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER J. H. Kelly

11 BIRTHPLACE OF FATHER (city or town) Lonaconing Md
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Byrnes

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Records
(Address)

15 Robert P. Harrison, Registrar
NOV 27 1923 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1923, to 11-27, 1923, that I last saw her alive on 11-27, 1923, and that death occurred, on the date stated above, at 3½ a. m.

The CAUSE OF DEATH* was as follows:

Tetany.

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Nov. 29 1923

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 1714 Eutaw Pl.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81220

CERTIFICATE OF DEATH.

154-02 D 81220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. (WARD) 26

2-FULL NAME Henry Graham

(a) RESIDENCE NO. 106 N. 11th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? — yrs. 1 mos. 28 ds.

(If non-resident give city or town and State).

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Graham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mimie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant William Graham
(Address) 106 E 11th St

15 Filed NOV 27 1923 16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1923, to Nov. 26, 1923, that I last saw h— alive on Nov. 26, 1923, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Congenital hypertrophic stenosis of the pylorus

(duration) yrs. 1 mos 26 ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 22 - Nov. 7

Was there an autopsy? Yes

What test confirmed diagnosis? Operation, symptoms and autopsy

(Signed) B. M. Rhoades M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Nov 28 1923

20 UNDERTAKER Peter Nicolaus & W. Eaton ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 81221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 E. 27 ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lindley Cargill

(a) RESIDENCE NO. 311 E. 27 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 31-1864

7 AGE — Years: 59 Months: 3 Days: 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: James Cargill

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary A. Lindley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Nelson F. Cargill

(Address) 311 E. 27th

15 Filed NOV 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1923, to Nov. 26, 1923,

that I last saw h alive on Nov. 24, 1923,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Liver

(duration) of Symptoms ^ yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 11, 1923

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) L. Clarence Cohn, M. D.

, 19 (Address) 1829 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — DATE OF BURIAL: Nov 28 19 3

20 UNDERTAKER: Wm. J. Tschiesz — ADDRESS: Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 81222

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3229 Abell Ave ST., 12 WARD)

2-FULL NAME Louis George Landbeck

(a) RESIDENCE NO. 3229 Abell ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Landbeck.

6 DATE OF BIRTH (month, day, and year) Mch 19-1858

7 AGE — Years: 65 — Months: 8 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): Paving Comm.

(c) Name of employer: Balto. City.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Christian Landbeck.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Emma Landbeck 3229 Abell ave.

15 Filed NOV 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 19 23.

17 I HEREBY CERTIFY, That I attended deceased from July 5 19 23 to Nov 27 19 23.

that I last saw him alive on Nov. 26 19 23

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder + Ducts with involvement of Liver.

(Duration) yrs. 4 mos 22 ds.

CONTRIBUTORY (Secondary) Forgotten

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? Yes. Date of Aug 25. 1923.

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) George Asher Barnes, M. D.

11/27 1923 (Address) 15 Ry & North avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — DATE OF BURIAL: Nov 29 1923

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2178 Pac.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

167917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81223

D 81223

CERTIFICATE OF DEATH.

X 49

REGISTERED NO. .....

1-PLACE OF DEATH Johns Hopkins Hosp

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

2-FULL NAME Herman J. Weisner

(a) RESIDENCE No. 669-26th St Milwaukee, Wis. WARD Milwaukee Wis

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Herman Weisner

6 DATE OF BIRTH (month, day, and year) June 4, 1898

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
25	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier Railroad office

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10 NAME OF FATHER John M. Weisner

11 BIRTHPLACE OF FATHER (city or town) Wis (State or country)

12 MAIDEN NAME OF MOTHER Josephine Ball

13 BIRTHPLACE OF MOTHER (city or town) Wis (State or country)

14 Informant Johns Hopkins Hosp (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1923, to Nov 27, 1923.

that I last saw him alive on Nov 27, 1923.

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wisconsin

Did an operation precede death? Yes Date of 11-27-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Theobald, M. D.

11-27 1923 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Milwaukee, Wis.

DATE OF BURIAL 11/27 1923

20 UNDERTAKER J. A. Brown

ADDRESS 30a E Baltimore

NOV 27 1923

Robert P. Harrison, Burial Permit Clerk.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tumor - Malignant

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Lueck)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81224

CERTIFICATE OF DEATH.

D 81224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1831 Frederick Ave ST. 19 WARD)

2-FULL NAME Wm C. Lueck

(a) RESIDENCE. NO. 1831 Frdk Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie M. Lueck

6 DATE OF BIRTH (month, day, and year) June 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Lueck

(c) Name of employer C H

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie M. Lueck (Address) 1831 Frederick Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1923 to Nov 27 1923.

that I last saw h[illegible] alive on Nov 26 1923.

and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH was as follows:

Acute dilation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter Power, M. D.

(Address) 324 Garrison Ave

11/27/23

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 30 19
20 UNDERTAKER	ADDRESS
E. Wm. Offutt, Jr.	1155 Garrison Lane

Robert P. Harrison, Registrar

NOV 27 1923

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81225

D 81225

CERTIFICATE OF DEATH.

74-09

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena A. Falconer

(a) RESIDENCE No. 536 N. Arlington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. ~~Falconer~~ Falconer

6 DATE OF BIRTH (month, day, and year) March 20 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James A. Dubel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Wittman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John M. Falconer

(Address) 536 N. Arlington ave

15 Filed NOV 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Nov. 27, 1923, that I last saw her alive on 11/27/23, 1923, and that death occurred, on the date stated above, at 11 0m m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Repeated attacks)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H.S. Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 28 1923

20 UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81226

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 81226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Walbert Apartments St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Levy

(a) Residence No. Walbert Apartments St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Levy

6-DATE OF BIRTH (month, day and year) Jan. 1854

7-AGE. 69 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Managing Editor

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer Journal Company

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Hiram Levy

11-BIRTHPLACE OF FATHER (city or town) Paris (State or Country), France

12-MAIDEN NAME OF MOTHER, Mary Porter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Stuart M. Daniel

(Address) Walbert Apartments

15- Filed ..... 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 27 1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20, 19 23, to Nov. 27, 19 23, that I last saw him alive on Nov. 26, 19 23, and that death occurred, on the date stated above, at 4.20 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert L. Mitchell, M. D.

11-27-1923 (Address) 2112 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hagerstown, Md. DATE OF BURIAL. Nov 28 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N Eutaw St

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81227

CERTIFICATE OF DEATH.

90 D 81227

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6212 Wilden Ave St., Forest Park WARD)

2-FULL NAME Charles H. Williams

(a) RESIDENCE NO 6212 Wilden Ave ST., Forest Park WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Vera Williams

6 DATE OF BIRTH (month, day, and year) Nov 8, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Hasbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Vera Williams
(Address) 6212 Wilden Ave

15 Filed NOV 27 1923 Robert P. Harrison, Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. H. Grusen M. D.
(Coroner.)

Nov 27, 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Nov 29 1923

20 UNDERTAKER Wm Cook & Son E. Lanvale — ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-21—M&T—100 Blks.

D 81228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81228

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 600 Crawford St ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred O. Forwood

(a) RESIDENCE NO 600 Crawford St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 weeks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Forwood

6 DATE OF BIRTH (month, day, and year) June 21/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Wesley Forwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER ---McFadden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant Lawrence Forwood (Address) 600 Crawford St.

15 Filed NOV 27 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26/23 [19]92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insuffiency

(duration) 1 yrs. mos. ds.

(Signed) J. H. Waller, M. D. (Coroner.)

Nov 27/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rock Springs Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Springs, Harford Co — DATE OF BURIAL 11/28 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 81229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 81229

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 Gough ST., 3 WARD)

2-FULL NAME Owen Brady

(a) RESIDENCE NO 1429 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	66	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER E. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant E. Cook
(Address) Dundalk

15 NOV 28 1923 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

A Suicide by Hanging

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

Nov 28, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Phila

DATE OF BURIAL Nov 28 1923

20 UNDERTAKER A. Jones

ADDRESS 111 S. Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stoc—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81230

CERTIFICATE OF DEATH.

90 D 81230

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Strathmore Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Alice K. Gardner

(a) Residence No. Strathmore ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6-DATE OF BIRTH (month, day and year): Sept 9/1863

7-AGE: 60 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: nothing

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Wm H Gardner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Emma E Humphrey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-(Informant) L W Warren

(Address) Strathmore Ave

15- NOV 28 1923 ROBERT B. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 27. 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1923 to Nov. 27 1923

that I last saw her alive on Died Suddenly 1923

and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

Sudden Death

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walton Poole M. D.

, 19 (Address) Eylisar - Rusulstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Methodist Episcopal

DATE OF BURIAL, Nov 30, 1923

20-UNDERTAKER: Josiah Lyter

ADDRESS: 1606 N North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chr. Myocarditis

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-006 D 81231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 N Northwood ST., 14 WARD)

2-FULL NAME Eliza J. Paul

(a) RESIDENCE NO. 1617 N. North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Robt J Lawrenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER [redacted] Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Thom K Paul (Address) 1617 N Northwood

15 Filed NOV 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby, 1914, to Nov 26, 1923, that I last saw h[illegible] alive on Nov. 26, 1923 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2½ ds.

CONTRIBUTORY (Secondary) Cerebral Hem (First Stroke)

(duration) 9 yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. K. Duvall, M. D.

Nov 26 1923 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park — DATE OF BURIAL Nov 29 1923

20 UNDERTAKER Josiah Syper — ADDRESS 1000 N North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81232

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 81232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 3202 Old York Road St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina E Wescott

(a) Residence No. 3202 Old York Road St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 21 1845

7-AGE. 78 yrs. 8 mos. 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. nothing

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Herman Pahl

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna Temmermeister

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Hermina E Pahl

(Address) 3202 York Road

15- Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 26/23

17- I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923 to Nov 26 1923

that I last saw h alive on Nov 25 1923

and that death occurred, on the date stated above, at 5a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) R. G. Gibbs M. D.

11/27, 1923 (Address) 6 W Mulberry

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL. Nov 29, 1923

20-UNDERTAKER. Joseph Speer — ADDRESS 1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81233

CERTIFICATE OF DEATH

1 PLACE OF DEATH 2100 E Baltimore Street

City of BALTIMORE: (No. Home for Incurables St., 6 Ward)

Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Dutin

(a) Residence No. 114 Jackson Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Dutin

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levin's

(Address) 1439 E Balto St

15-

Filed ..... 192..... ROBERT R. KRAUTER, Registrar.

NOV 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/27/23

17- I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov 27, 1923

that I last saw h. alive on Nov 27 1923

and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

~~Chronic Colitis~~

Cerebral Hemorrhage

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Whitebourne M. D.

19 (Address) 1818 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Int Carmel — DATE OF BURIAL, Nov 28 1923

20-UNDERTAKER, Jack Levin — ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81234

CERTIFICATE OF DEATH.

Registered No. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 S. Port St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kripp

(a) Residence No. 519 S. Port St., 1 Ward.
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): April 4. 1849

7-AGE: 74 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer): on street

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: John Kripp

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore City

12-MAIDEN NAME OF MOTHER: Margaret Engelsiter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs Wimps

(Address): 519 S. Port St

15- Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 26-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov 26, 1923, that I last saw h[illegible] alive on Nov 16, 1923, and that death occurred, on the date stated above, at 6.45 P m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.

11/27, 1923 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Nov 29 1923

20-UNDERTAKER: Robt J Turner

ADDRESS: N & Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81235

CERTIFICATE OF DEATH.

117

D 81235

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian G. Riesdorf

(a) RESIDENCE NO. 4724 Locust Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 10 1881

7 AGE: Years 42 Months Days

If LESS than 1 day, hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dallas

PARENTS

10 NAME OF FATHER: James D Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dallas Tex

12 MAIDEN NAME OF MOTHER: Amelia Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Pascal E Riesdorf

(Address) 4724 Locust Ave

15 Filed NOV 28 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-27 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Nov 21, 1923

that I last saw h alive on Nov 21, 1923

and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure due to sepsis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Ruptured Appendix

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 11-18-23, 11-26-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard M Kemp M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallas Texas

DATE OF BURIAL: Nov 30 1923

20 UNDERTAKER: Eckhardt

ADDRESS: Dallas Texas

ROBERT [illegible] REGISTRAR

BUREAU PERMIT CLERK

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81236

CERTIFICATE OF DEATH.

74-091

D 81236

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 N Fanwalk St., 11 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hamie A. Malloy

(a) Residence No. 116 N Fanwalk St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of John F. Malloy

6-DATE OF BIRTH (month, day and year) July 8 1839

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of Industry, business, or establishment in which employed (or employer). 000

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Thos. A. Sollers.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Martha Valentine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Miss Mary C. Malloy.

(Address) 116 N. Fanwalk St.

15- Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 27 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1923 to Nov 27 1923 that I last saw h[illegible] alive on Nov 27 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 24 hrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? All tests [illegible]

(Signed) Means Lathia Chapman M. D

Nov 28, 1923 (Address) 2439 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral

DATE OF BURIAL. Nov 30 1923

20-UNDERTAKER. E & B Hart

ADDRESS 115 E West St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81237

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Aisquith St.; 9 WARD)

REGISTERED No. C 10001 D 81237

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Augusta Logan

(Residence in Baltimore: No. 1902 Aisquith St.; 1 yrs., 8 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. FEB (Month) 8 (Day), 1923 (Year)

7-AGE. X yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Harrison Logan

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary Alice Stanton

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Alice Logan

(Address) 1902 Aisquith St

15-

Filed NOV 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from NOV 22 1923 191, to NOV 26 1923 191, that I saw h alive on NOV 26 1923 191, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) O. H. Dutton M. D.

NOV 27 1923, 192... (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov 28, 1923

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81238

D 81238

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 858 N Lexington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henderson Williams

(a) RESIDENCE NO. 858 N. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4c yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 074

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Rose Williams

(Address): 858 N. Lexington

15 Filed NOV 28 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 3 1923, to Nov 17, 1923, that I last saw h alive on Nov 16, 1923 and that death occurred, on the date stated above, at 4 h 4 m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of?

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Norwood M. D.

, 19 (Address) 709 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery

DATE OF BURIAL: Nov 30 1923

20 UNDERTAKER: Edward Boyce

ADDRESS: 631 Park Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81239

CERTIFICATE OF DEATH.

101-001

D 81239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712, N. Vincent ST., 16 WARD)

2-FULL NAME Pinkney Ferguson

(a) RESIDENCE No. 712, N. Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE: Years 39; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer 170

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frana Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Addie Ferguson

(Address) 1211, Lawrence St

15 Filed NOV 28 1923 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25 - , 1923, to Nov. 26 - , 1923, that I last saw h alive on Nov. 26 - , 1923 and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. C. McCarthy, M. D.

11-27 1923 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 29 1923

20 UNDERTAKER: Jno. M. Chase & Son

ADDRESS: 1400 Mosher

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 81240 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81240

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Vickers Road ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora M. Beeler

(a) RESIDENCE. NO. 3206 Vickers Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rollin Beeler

6 DATE OF BIRTH (month, day, and year) Dec 11-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm L Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Adin B. Beeler (Address) 3206 Vickers Road

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

NOV 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Nov. 26, 1923, that I last saw h[illegible] alive on Nov 26, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart. disease

about (duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? 1318 McCulloh St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Gilroy M. D.

, 19 (Address) 1500 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Nov 30/23 19

20 UNDERTAKER: Chas. E. Franck ADDRESS: 822 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 81241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 E. 37th. ST., 13 WARD)

2-FULL NAME Ulysses S. Fisher

(a) RESIDENCE NO. 1009 E. 37th. ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 22. 1864

7 AGE — Years: 59 — Months: 1 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Roamy Hand

(b) General nature of industry, business, or establishment in which employed (or employer): Mt. Vernon Woodbury Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City. Maryland

PARENTS

10 NAME OF FATHER: Albert Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sarah E. Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Elmira F. Phillips 1009 E. 37th St

Filed NOV 28 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1923 to Nov 26 1923

that I last saw h live on Nov 25 1923.

and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

about 1 yr

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) M. A. Fiske, M. D.

(Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden — DATE OF BURIAL: Nov. 29 1923

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 2 Hallsdale

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81242

100-00 D 81242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 Castle ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Langmuir

(a) RESIDENCE NO. 214 S. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Langmuir

6 DATE OF BIRTH (month, day, and year) July 6 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS.

10 NAME OF FATHER John F. Bollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bollinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Edna. Mahon & 120 S. Castle St.

15 Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Nov 27, 1923, that I last saw her alive on Nov 26, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Maurice H. Grabow, M. D.

(Address) 3525 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel	Nov. 30 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 E. N. Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81243

100-001 D 81243.

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 76 WARD).

2-FULL NAME Christian Hendrickson

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed NOV 28 1923, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 9, 19 23 to November 25, 19 23, that I last saw h im alive on November 25, 19 23, and that death occurred, on the date stated above, at 6:40 P.M. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A. Hoss, M. D.

11-27, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL (Nov. 29, 19 23

20 UNDERTAKER Sickler & Pirkler

ADDRESS 1939 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81244

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1310 Hull St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine R. Cadden

(a) Residence No. 1310 Hull St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23, 1906

7-AGE. 17 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Cuero Texas (State or Country),

PARENTS:

10-NAME OF FATHER, Robert J. Cadden

11-BIRTHPLACE OF FATHER (city or town) W. Va. (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret O'Connor

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country),

14-

(Informant) Robt. J. Cadden

(Address) 1310 Hull St

15-

Filed NOV 28 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 26 1923

17- I HEREBY CERTIFY, That I attended deceased from May 1 1920 to Nov. 26 1923.

that I last saw h[illegible] alive on Nov 25 1923

and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. 7 mos. 25 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens M. D

" 27. 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL, Nov 29 1923

20-UNDERTAKER: Wm E. Miller

ADDRESS 2334 Gilmor

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81245

CERTIFICATE OF DEATH.

113 D 81245

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Preece st ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jones

(a) RESIDENCE NO. 526 Preece st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2-1923

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		5-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Raymond Ware

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant Bertha Jones
(Address) 526 Preece st

15 Filed NOV 28 1923 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Justo Entericus

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Dom Bron

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) T T Somerville, M. D.
(Coroner.)

11-27, 1923 (Address) 1117 W Baltimore st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 29 1923

20 UNDERTAKER R C Gross

ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81246

D 81246

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 10 WARD)

2-FULL NAME Edna G. Bishop

(a) RESIDENCE NO. 741 Ajax st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE — Years: 26 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER James G. Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Sarah E. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1923, to Nov. 25, 1923,

that I last saw her alive on Nov. 25, 1923,

and that death occurred, on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 5 weeks mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. G. Lell, M. D.

19 (Address) 11-26-23 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Nov. 28 1923

20 UNDERTAKER: Mrs Chas B Jones

ADDRESS: 1725 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81247

CERTIFICATE OF DEATH.

90 D 81247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith ST., 5 WARD)

2-FULL NAME Nathan Bruson

(a) RESIDENCE NO. 207 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St George Co Md

PARENTS

10 NAME OF FATHER Nathan Bruson

11 BIRTHPLACE OF FATHER (city or town) (State or country) St George Co

12 MAIDEN NAME OF MOTHER Avery Bacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St George Co Md

14 Informant Nathan Bruson (Address) 207 Aisquith St (Deceased)

15 Filed NOV 28 1923, 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Nov 25, 1923, that I last saw h— alive on Nov 22, 1923, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) dilatation of heart

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C

(Signed) J. Edward Fisher, M. D.

11-27-1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Not embalmed — DATE OF BURIAL Nov 28 1923

20 UNDERTAKER Samuel T Kennedy — ADDRESS 578 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D 81248

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2239 Oreen Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. LOUISA SELBY

(a) Residence No. 2239 Oreen Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Male~~ Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widow, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Marshall S Selby

6-DATE OF BIRTH (month, day and year) June 12, 1832

7-AGE. 91 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Shipley Carroll Co, Md.

PARENTS:

10-NAME OF FATHER. Frank Shipley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co Md.

12-MAIDEN NAME OF MOTHER. Jane Frizzell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Shipley Carroll Co Md

14-

(Informant). Mrs Minnie V Selby

(Address). 2239 Oreen ave

15-

Filed NOV 28 1923 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 26, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1923 to Nov 26 1923

that I last saw h[illegible] alive on Nov 26 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John R Hutchcombie M. D.

19 (Address) 2574 Greenmount Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Old Freedom Sault Co	Nov 29 1923

20-UNDERTAKER.	ADDRESS.
H M Rowson	2238 Ensor

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81249

CERTIFICATE OF DEATH.

3 D 81249

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 7 WARD)

2-FULL NAME Mary Senkyr

(a) RESIDENCE NO. 813 N. Port st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Senkyr

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. T. Morlan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Barrett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address) M.T.H.

15 NOV 28 1923 , 19 Registrar

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to Nov. 26, 1923, that I last saw her alive on Nov. 26, 1923, and that death occurred, on the date stated above, at 10.40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Labby, M. D.

11-26-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 30 1923

20 UNDERTAKER Enoch Grace & Son — ADDRESS Nov 30 23 1900 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 31250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31250

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2782 Almeda ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Yast

(Residence in Baltimore: No. 2782 Almeda ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 29, 1863 (Month) (Day) (Year)

7-AGE, 60 yrs. 5 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): 601

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Yast

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Caroline Linn

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wife Geo Hayward

(Address) 2782 Almeda ave

15-

Filed ....., 191.....

Robert P. Harrison,

Burial Permit Clerk,

Registrar.

NOV 28 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to November 27 1923, that I saw h[illegible] alive on November 26 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ....yrs. 12 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem DATE OF BURIAL: Nov 30, 1923

20-UNDERTAKER: F. A. Krause & Son ADDRESS: 7. 3 Warner

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to write PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81251

CERTIFICATE OF DEATH.

75-00 D 81251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Beigel

(a) RESIDENCE No. 419 S. 13th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ? 11-27-23

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital. Records. (Address)

15 Filed . 19 Robert P. Harrison, Registrar

NOV 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from October 11 . 1923 , to November 27. 1923.

that I last saw her alive on November 26 . 1923,

and that death occurred, on the date stated above, at 6:25 A.M. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

Left Hemiplegia (Residual)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Heuer, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Nov. 30. 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81252

129 D 81252

CERTIFICATE OF DEATH.

D 81252

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3502 Bank St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Janney

(a) Residence No. 3502 Bank St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Janney

6-DATE OF BIRTH (month, day and year) June 30, 1837

7-AGE. 86 yrs. 4 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Doctor
(b) General nature of industry, business, or establishment in which employed (or employer) M.D.
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.
10-NAME OF FATHER. Daniel Janney
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia
12-MAIDEN NAME OF MOTHER. Not Known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14- (Informant) Esther Janney
(Address) 3502 Bank St.

15- Filed NOV 28 1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 28 1923

17- I HEREBY CERTIFY, That I attended deceased from May 12 1923 to Nov 28 1923 that I last saw h.~~im~~ alive on Nov 27 1923 and that death occurred, on the date stated above, at 3 A, m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) x yrs. x mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Brights disease (Duration) 1 yrs. x mos. x ds.

18-Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same

(Signed) Jas. L. Truax M. D

Nov 28. 1923 (Address) 248 50 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Friends Cem.	Nov. 30 1923
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Park Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81253

CERTIFICATE OF DEATH.

65-001 ✓ D 81253

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Barr

(a) RESIDENCE No. 4317 Harford ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Margaret E. Barr

6 DATE OF BIRTH (month, day, and year) Dec. 14-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	57	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert P. Barr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Boulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Hospital Records. (Address)

15 Filed ..., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1923, to Nov 26, 1923, that I last saw him alive on Nov 26, 1923, and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Chronic Lymphatic Leukaemia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John Hall, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cecil Co. Md. DATE OF BURIAL Nov. 29 1923

20 UNDERTAKER Wm. G. Black ADDRESS 927 N. Broadway

NOV 28 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81254

CERTIFICATE OF DEATH.

161-90 ✓ D 81254

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., 18 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Louise Weber

(a) RESIDENCE No. 837 Hollins St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred ~~yrs.~~ life mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town) ? (State or country)
12 MAIDEN NAME OF MOTHER Louise Weber
13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant ..... (Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

NOV 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923, to Nov. 20, 1923, that I last saw h[illegible] alive on November 20, 1923, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Born at 837 Hollins

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) H. H. Mosch M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

0909

WARNING—RESERVED FOR CERTIFICATION

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81255

CERTIFICATE OF DEATH.

43 D 81255

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Scott

(a) Residence No. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE.	If LESS than 1 day.
47 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Driver 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Rufus Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Checker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Municipal Hospital Records.

(Address) JOHNS

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 6 to 23 to November 25 to 23

that I last saw him alive on November 25 to 23

and that death occurred, on the date stated above, at 7:50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma - Superior Maxilla - Right

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Pathological Exam. & Section

(Signed) M. J. Fulton, M. D.

11-26-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	NOV 28 1923 19
20-UNDERTAKER.	ADDRESS

Commissioner of Health.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 28 1923

9968

Spec.—1-10-21—M&T—1500 Bks.

D 81256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81256

CERTIFICATE OF DEATH.

161-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Raborg ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Queen

(a) RESIDENCE NO. 1113 Raborg ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25, 1923

7 AGE — Years — Months — Days — If LESS than 1 day hrs. or min. 11½ hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Queen

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Pearl Harris

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Father (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Robert E. Harrison, Registrar

NOV 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1923 to Nov 26, 1923

that I last saw h[illegible] alive on Nov 26, 1923

and that death occurred, on the date stated above, at 10 A m

The CAUSE OF DEATH* was as follows:

Prematurity -

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harris Neal, M. D.

11/26, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

Commissioner Health.

Deputy Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81257

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 D 81257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Institute of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Halpin

(a) Residence No. Preston & Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Andrew Halpin

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Ellen Joffrey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-

(Informant) Sister Florence

(Address) Preston & Caroline

15-

Filed 19

Registrar.

NOV 28 1923

Robert P. Harrison,

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-27-23

17- I HEREBY CERTIFY, That I attended deceased from 11-20 1923 to 11-27 1923 that I last saw her alive on 11-26 1923 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Bernard Wyatt M. D

11-28-1923 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral

DATE OF BURIAL. Nov 30 1923

20-UNDERTAKER. H. C. Wiedefeld

ADDRESS 914 Greenmt Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 81258

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) Residence No. 2013 Remington Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 27 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Edward Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Francis Little

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, 192 Registrar.

NOV 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from October 30 19 23 to November 26 19 23

that I last saw him alive on November 26 19 23

and that death occurred, on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
involving Rectum
Colloid

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy, Pathological Exam.

(Signed) Wm. D. Faulks M. D.

11-28-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery DATE OF BURIAL. Nov 30 1923

20-UNDERTAKER. R. S. Marshall ADDRESS 3539 Falls Rd

IN B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81259 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81259

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmondson Ave. Ten Hills ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Molloy

(a) RESIDENCE NO. Edmondson Ave. Ten Hills ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 14, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Molloy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Cosgrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James H. Molloy (Address) Edmondson Ave. Ten Hills

ROBERT R. KRAUTER

15 Filed NOV 29 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Nov 27, 1923, that I last saw her alive on Nov 27, 1923, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Cap. plexus)

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'neill, M. D.

11/28, 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 11/29/23 19

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81260

CERTIFICATE OF DEATH.

X 170 D 81260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo H. Altstadt

(a) RESIDENCE NO. Fort Howard, ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Dept. Eastern Dist
(Address)

15 Filed NOV 29 1923, 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Suicide - Shot self through left breast
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) Chas E. Hunter M. D.
(Coroner)
Nov 28, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa — DATE OF BURIAL 11/29 1923

20 UNDERTAKER A. Lennson & Bro — ADDRESS 1127 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81261

CERTIFICATE OF DEATH.

22-002

D 81261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore Gen Hosp ST., 3 WARD)

2-FULL NAME Louis M Weinberg

(a) RESIDENCE NO. 23 S. Peter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER David Weinberg

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Meinbloom

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant David Weinberg
(Address) 235 S. Peter st

15 Filed [illegible] 19 ROBERT R. KRAUTER, Registrar
NOV 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28 1923

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1923 to November 26, 1923.

that I last saw him alive on November 26, 1923

and that death occurred, on the date stated above, at 11 9. m

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Anemia of Liver

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John A. Colmore, M. D.

19 [illegible] (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hening Pur

DATE OF BURIAL 11/29 1923

20 UNDERTAKER A. Lainson & Bro

ADDRESS 227 E. Balto st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81262

CERTIFICATE OF DEATH.

57 D 81262

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Exler

(a) RESIDENCE NO. 1724 N. Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Exler

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 30 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Gellman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Gutkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1923, to Nov. 28, 1923, that I last saw her alive on Nov. 28, 1923, and that death occurred, on the date stated above, at 10.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus & Cholecystitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidor D. Jay M. D.

Nov , 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 11/29 1923

20 UNDERTAKER: Jack Lewis 1439 E Baltimore St

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31263

CERTIFICATE OF DEATH.

101-001 D 31263

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3623 Maple Ave St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F Frock

(a) RESIDENCE No. 3623 Maple Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? 30 yrs. yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude H Frock

6 DATE OF BIRTH (month, day, and year): Aug 1 1856

7 AGE: Years 67 Months 3 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Samuel Frock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Wenzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: George Frock Jr (Address) 3623 Maple Ave

15 Filed NOV 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923 to Nov. 27, 1923 that I last saw h[illegible] alive on Nov. 27, 1923 and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

PC Uremic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, Contrib

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) C. F. Campbell M. D.

11-27-1923 (Address) 3701 Reed Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sisters Balto Co DATE OF BURIAL: Nov 30 1923

20 UNDERTAKER: SHENOWETH & SON ADDRESS: 3617 CHESTNUT AVE

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 81264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81264

CERTIFICATE OF DEATH.

100-00

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Smith

(a) RESIDENCE NO. Perryman Md Box 24 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 1 month ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8, 1922

7 AGE — Years: 1 — Months: — — Days: 20 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Minnie Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Record
(Address): Johns Hopkins Hosp

15 Filed NOV 29 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Nov 28, 1923, that I last saw h[illegible] alive on Nov 28, 1923, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. L. Bagley, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md — DATE OF BURIAL: 11/29 1923

20 UNDERTAKER: Wm. J. Tickner Son — ADDRESS: Bath & Penn

Spec.—6-9-19—H. P. Co.—1000 Blks.

81265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 81265

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Jenkins St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Underwood.

(a) RESIDENCE. No. 1024 Jenkins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): NOV 25 1923

7 AGE: Years ..... Months ..... Days 2

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Clarence Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Edith Underwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edith Underwood
(Address) 1024 Jenkins St.

15 Filed NOV 29 1923 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from 11.25, 1923, to 11.27, 1923, that I last saw h[illegible] alive on 11.26, 1923, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows: Prematurity birth: 6½ mos
Lived 24 hours -

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

, 19 (Address) 211 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 11/30 1923

20 UNDERTAKER: James F. Dennis — ADDRESS: 203 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Wm Harmond ✓

D 81266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81266

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 W Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Harmond,

(a) RESIDENCE NO. 520 W Saratoga St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wesley Harmond

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Day

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Sarah Thomas
(Address) 520 W Saratoga St

15 Filed NOV 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W W Gamel, M. D.
(Coroner.)

11-28, 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 11/30 1923

20 UNDERTAKER James F. Dant — ADDRESS 203 Freedman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 81267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81267

CERTIFICATE OF DEATH.

174-00½ V

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 N. Paca St., St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Jones

(Residence in Baltimore: No. 607 N. Paca St., St.; yrs. 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widow(er), or Divorced. (Write the word.): Married

6-DATE OF BIRTH: August (Month) 1 (Day) 87 (Year)

7-AGE: 47 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE (State or Country): Wash. D. C.

PARENTS

10-NAME OF FATHER: [illegible]

11-BIRTHPLACE OF FATHER (State or Country): [illegible]

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (State or Country): [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Jones

(Address) 607 N. Paca St.

15-

Filed NOV 29 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary): no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Nov. 28 1923 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Washington D.C. DATE OF BURIAL: Nov 29 1923

20-UNDERTAKER: Saml H. Chase Son ADDRESS: 400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH CAPACITY FOR ...

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81268

D 81268

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 23 WARD)

2-FULL NAME Walter Clayton

(a) RESIDENCE No. 1113 Race St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co., Md.

PARENTS

10 NAME OF FATHER George Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Record.

(Address)

15 Filed NOV 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1923, to November 27, 1923, that I last saw h im alive on November 27, 1923, and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 5 mos (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde B. Moss, M. D.

11-28-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 30, 23

20 UNDERTAKER John H. Todderman — ADDRESS 1122 Mt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81269

129 V D 81269

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hosp Charles St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas R Brady

(Residence in Baltimore: No. 1015 N Fayette St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, September 25, 1842
(Month) (Day) (Year)

7-AGE, 81 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Missouri

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J Brady

(Address) Goldsboro Maryland

15- NOV 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.
Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1921, to Nov 28th 1923 that I saw him alive on Nov 28th 1923 and that death occurred, on the date stated above, at 9.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) 2 yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Augustus Thom M. D.

....., 191... (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Goldsboro Missouri	Nov 29, 1923
20-UNDERTAKER George J Smith	ADDRESS 1532 Holmead

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81270

CERTIFICATE OF DEATH.

161-OD 81270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 "Thompson St. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Girl" Eskridge

(a) RESIDENCE NO 1114 Thomson St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Nov 28/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				7

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Eskridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Robert Eskridge
(Address) 1114 Thompson St.

15 NOV 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28/1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity-eight mons. gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Power, M. D.
(Coroner)

Nov. 28/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cemetery	Nov 29 1923
20 UNDERTAKER Edward Bryon	ADDRESS 631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81271

CERTIFICATE OF DEATH.

179 D 81271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Light ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret W Shipley

(a) RESIDENCE. NO. 1228 Light ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Shipley

6 DATE OF BIRTH (month, day, and year) June 3 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Christina Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Elizabeth Sullivan
(Address) 1228 Light St

15 Filed NOV 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1923, to Nov 27, 1923, that I last saw her alive on Nov 27, 1923, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio vascular disease (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. test

(Signed) Wm E Light, M. D.

11/28, 1923 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 30 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81272

CERTIFICATE OF DEATH.

113 D 81272

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital

2-FULL NAME William Howard (James) Ey

(a) RESIDENCE NO. 1111 South Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. 26 How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1923

7 AGE: Years | Months: 9 | Days: 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Herman Ey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Cecilia Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Maryland

14 Informant: Mother (Mrs. [illegible]) (Address) 1111 S Paca St.

15 Filed NOV 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1923, to Nov. 28, 1923, that I last saw h alive on Nov. 28, 1923, and that death occurred, on the date stated above, at 9 ff. m.

The CAUSE OF DEATH* was as follows:

Pneumonitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: 11/30 1923

UNDERTAKER: William Cook — ADDRESS: 502 E Niny

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81273

CERTIFICATE OF DEATH.

D 81273

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 10 E Street Ward 45 Park ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara M Seaderer

(a) RESIDENCE No. 10 E Dr Morrell St. Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W Seaderer

6 DATE OF BIRTH (month, day, and year) Wards 11-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick W. Seaderer
(Address) 10 E Dr Morrell Park

15 Filed NOV 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clark.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Collar Bone

(duration) yrs. mos. ds.

(Signed) G. Clinton Black, M. D. (Coroner.)

Nov 29 1923 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/1 1923

20 UNDERTAKER M Cook — ADDRESS 502 E Nor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81274

CERTIFICATE OF DEATH.

D 81274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 456 (St.) Pinkney (Ward) Race

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Lawlor

(a) RESIDENCE NO. 456 Pinkney ST., ... WARD Race

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 If Single, Married, Widowed or Divorced (write word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Edith G. Lawlor

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 57 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Meat Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 013
(c) Name of employer: Gildenhorn Son

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Lawlor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Winifield Quirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Edith G Lawlor
(Address) 456 Pinkney place

15 Filed DEC 29 1923, 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (duration) yrs. (mos) ds.

CONTRIBUTORY (Secondary) History of indigestion for month

(duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Dec 29, 192 3 (Address) 763 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: 12/1 192 3

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Nor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—I-12-23—M&T—100 Bks.

curtis 0806 ✓ Horton curtis Bay

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81275

CERTIFICATE OF DEATH.

188-003 D 81275

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Dillon & 3rd St., 11 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis M. Brayden

(a) RESIDENCE No. 321 W. Biddle St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

(a) If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos W. Brayden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine Bressler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eugene Juinan
(Address) 2741 N. Calvert

15 Filed NOV 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

at once

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Removed by Trust

(duration) yrs. ..... mos. ..... ds.

(Signed) Geo. B. Horton M. D.
(Coroner.)

Nov. 29, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	11/30 1923
20 UNDERTAKER Chas Cook	ADDRESS 502 E. Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81276

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 81276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Calvert & 31st

CITY OF BALTIMORE: (No. Calvert Court Et ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ora Viola Mudge

(a) RESIDENCE NO. Calvert Court E/ ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of: Harry Mudge

6 DATE OF BIRTH (month, day, and year): July 21 1853

7 AGE: Years 70 Months 10 Days 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Geo Mrl Dear

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary A Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Harry Mudge

(Address) 31 & Calvert Et

15 Filed NOV 29 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sep 16, 1923, to Nov 28, 1923, that I last saw h er alive on Nov 28, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter R. White Jr, M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Nov 30 1923

20 UNDERTAKER: J H Jenkins Sons Co — ADDRESS: Cor of Gilmor & Gilbert Sts

Spec.—1-10-21—M&T—1500 Bks.

Vol. 0044

Dr Morrison
1913 N Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81277

45

D 81277

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 518 East Eager ST., 10 WARD)

2-FULL NAME Peter Short

(a) RESIDENCE NO. 518 East Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-1867

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Short

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McNaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret McNally

(Address) 518 E Eager

Filed NOV 29 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1923, to Nov. 28, 1923, that I last saw h.. alive on Nov. 27, 1923 and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of abdominal organs; primary growth in rectum

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 26/23

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Theodore N. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 11/30 1923

20 UNDERTAKER W. P. Cook — ADDRESS 502 E. N. Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 81278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hospital (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Brown

(a) RESIDENCE NO. 27 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Negro

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Brown

6 DATE OF BIRTH (month, day, and year) August 25, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Brown

(Address) 27 Edmondson Ave

Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1923

17

I HEREBY CERTIFY, That I attended deceased from 11/19, 1923, to 11/27, 1923,

that I last saw her alive on 11/27, 1923

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Suppurative Appendicitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/26

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Jackson M. D.

19 (Address) 808 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cemetery	Nov 30 1923
20 UNDERTAKER	ADDRESS 32 W. Lanvale St
Mrs Katie R. Williams	F. Schmeltz

Cor.—1-12-23—M&T—100 Blks.

D 81279

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

D 81279

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 So. High ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcus Adelman

(a) RESIDENCE NO. 38 So. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Adelman

6 DATE OF BIRTH (month, day, and year) Sept 14 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cap Cutter
(b) General nature of industry, business, or establishment in which employed (or employer),
(c) Name of employer S. Friedenberg 086

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Adelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isadore Adelman
(Address) 38 So. High St.

15 Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Robt. R. Horton, M. D. (Coroner.)

Nov 29 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 11/30 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

Spec.— 10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31280

CERTIFICATE OF DEATH.

60-08 D 81280

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Shaffer

(a) RESIDENCE NO. 2012 E. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Shoffer

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hirsh Harder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Chefa Boden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Eutaw St

15 Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Nov. 29, 1923, that I last saw her alive on Nov. 29, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation

Myocardial insufficiency

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre; Gangrene of leg.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidore I. Frey, M. D.

Nov. 30 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Int. Assoc. DATE OF BURIAL 11/30 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81281

CERTIFICATE OF DEATH.

1 86-005 D 81281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 13 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Webb

(a) RESIDENCE No. 3639 Roland Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 14 1911

7 AGE: Years 12 Months Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Albert Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Nettie Be

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hospital Record

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/29/23

17 I HEREBY CERTIFY, That I attended deceased from 11/19/23, 19, to 11/29/23, 19, that I last saw h alive on 11/29/23, 19, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Status Uremia Chronic

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis, Interstitial Acute Pneumonia - Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Postmortem

(Signed) K. W. Kelley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Nov 30, 23

20 UNDERTAKER: Cohen & Lorsch — ADDRESS: 3617 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81282

CERTIFICATE OF DEATH

90 D 81282

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 3214 Barclay St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Lead

(Residence in Baltimore: No. 3214 Barclay St. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

6-DATE OF BIRTH, November 27 1883
(Month) (Day) (Year)

7-AGE 60 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Henrietta Lead

13-BIRTHPLACE OF MOTHER, (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Brooks

(Address) 1021 Druid Hill Ave

15-

Filed NOV 30 1923, 19..

ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular Disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm H Forrester M. D.
(Coroner)

11/28 1923 (Address) 2522 Rolandon

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: 11/30 19 23

UNDERTAKER: Saml T. Hawley ADDRESS: W Balto

Spec.—1-10-21—M&T—1500 Blks.

Brownes.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81283

CERTIFICATE OF DEATH.

40

D 81283

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE (No. 1112 N. Front ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julian Brunyer

(a) RESIDENCE NO. 906 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 8/29/1902

7 AGE: Years 21 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Atlanta, Ga.

PARENTS

10 NAME OF FATHER: Lawrence Brunyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant (Address): Emma Jones 906 N Eutaw St.

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/29 19 23

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 19 23, to 11/29, 19 23, that I last saw h[im] alive on 11/29, 19 23, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis - Subacute

5 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. J. Insoman, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 12/1/23

UNDERTAKER: Saml T Hemsley

ADDRESS: 1378 Bdle

Spec. 1-10-21 MAT 1500 Blks.

D 81284 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 81284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME Jane Dorman

(a) RESIDENCE NO. 2107 N. Charles St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1853

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: J. F. Mealey.

9 BIRTHPLACE (city or town) (State or country): Salisbury Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records

(Address): John Hopkins Hosp

15 Filed ....., 19 ..... Registrar

NOV 30 1923 ROBERT R. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1923, to Nov. 27, 1923, that I last saw h[illegible] alive on Nov. 27, 1923, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

3 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... Ft Howard

Did an operation precede death? Yes Date of Nov. 27, 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Section

(Signed) Warfield M. Jones M. D.

1128, 1923 (Address) Ft Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11/30 1923

20 UNDERTAKER: Samuel T. Hensley

ADDRESS: 857 Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81285

CERTIFICATE OF DEATH.

129 D 81285

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2140 East North Ave ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Elizabeth Kepler.

(Residence in Baltimore: No. 2140 East North Ave. St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, October 31, 1876
(Month) (Day) (Year)

7-AGE, 47 yrs. 1 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Schenectady N. Y.

PARENTS.

10-NAME OF FATHER, ?(?) Knight

11-BIRTHPLACE OF FATHER (State or Country), Schenectady N. Y.

12-MAIDEN NAME OF MOTHER Mattie Elizabeth Knight

13-BIRTHPLACE OF MOTHER (State or Country), Schenectady N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. John Delaney Gardner

(Address) 2140 E. North Ave.

15-

NOV 30 1923

ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 19 1923, to November 27 1923, that I saw her alive on November 27 1923, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
due to Arterial Hypertension

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. ds.

(Signed) Albert Cassenberg M. D.

Nov 27, 1923. (Address) 222 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery — DATE OF BURIAL, Nov 30 1923

20-UNDERTAKER George J. Russ — ADDRESS 1735 Hayford ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

J. Elizabeth Glanding

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81286

81286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Homewood Hosp

CITY OF BALTIMORE: (No. 2724 Charles St., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doctor E. Glanding

(a) RESIDENCE No. 1641 Ellamont St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Glanding

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Hammett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Priscilla M. Glanding
(Address) 1641 Ellamont St

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16 1923 to Nov. 29 1923, that I last saw h alive on Nov 27 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) Hematuria

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Microscopic

(Signed) Lee C. Fellows M. D.

11/27 1923 (Address) 2724 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Dec 1 1923

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81287

CERTIFICATE OF DEATH.

161-001 D 81287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 18 WARD)

2-FULL NAME Baby Wilhelms

(a) RESIDENCE NO. 1069 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28, 1923

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Helmuth Wilhelms

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York City

12 MAIDEN NAME OF MOTHER: Edith Martyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Helmuth Wilhelms

(Address) 1069 W Fayette St

15 Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1923, to Nov 28, 1923, that I last saw him alive on Nov 28, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Baby – Birth weight 2 lbs 2 z

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor I Fay M. D.

Nov. 30, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov 30 1923

20 UNDERTAKER: George A Smith

ADDRESS 1537 Hollins St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81288 D 81288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1459 Hull St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Worthington

(a) Residence No. 1522 Latrobe Pk Terrace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R. Worthington

6-DATE OF BIRTH (month, day and year): June 19- 1880

7-AGE: 43 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Robert Applegarth.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Julia A Stranley.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-INFORMANT: Chas R. Worthington

(Address): 1522 Latrobe Pk Terrace

15-FILED: NOV 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 28 1923

17- I HEREBY CERTIFY, That I attended deceased from April 9 1923 to Nov 28 1923

that I last saw h[er] alive on Nov 27 1923

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) yrs. 7 mos. 19 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1522 Latrobe Pk Terrace

Did an operation precede death? Yes Date of Apr. 9. 1923

Was there an autopsy? No.

What test confirmed diagnosis? Pathological specimen

(Signed) Thos. F. Stevens M. D

11/28, 1923 (Address) 2898 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Com — DATE OF BURIAL: Nov 31, 1923

20-UNDERTAKER: George F Smith — ADDRESS 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81289

CERTIFICATE OF DEATH.

129 ✓ D 81289

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1357 N Fremont Ave. (St.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Jackson

(a) RESIDENCE NO. 1357 N Fremont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Jackson

6 DATE OF BIRTH (month, day, and year) July 4 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52		4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Lucy Logan

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Mabel Jackson, Thomas (Address) 357 Fremont Ave.

15 Filed NOV 30 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to Nov 28, 1923, that I last saw her alive on Nov 27, 1923, and that death occurred, on the date stated above, at 215 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

11/29, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Va. DATE OF BURIAL 11-30 1923

20 UNDERTAKER David Easton ADDRESS 916 Penna.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81290

CERTIFICATE OF DEATH.

129 D 81290

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary M. C. Gill.

(a) RESIDENCE NO. 1803 N. Wolfe ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1885 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Waitress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mary Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Record.

15 NOV 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28/23

17

I HEREBY CERTIFY, That I attended deceased from 10/30/23, 19..., to 11/28/23, 19...,

that I last saw h[illegible] alive on 11/28/23, 19...,

and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. W. Holland M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 12/1 '23

20 UNDERTAKER: H. C. Waidelich ADDRESS: 914 Penn St

Spec.—1-10-21—M&T—1500 Bks.

D 81291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81291

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Madison Ave ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Robert Wright Mifflin

(a) RESIDENCE NO. 1016 Madison Ave ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 69 yrs. 11 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Ella Adams Mifflin

6 DATE OF BIRTH (month, day, and year): Dec. 23-1853

7 AGE — Years: 69 — Months: 11 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): Medicine

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germantown Penna

PARENTS

10 NAME OF FATHER: Saml. Wright Mifflin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Columbia Penna

12 MAIDEN NAME OF MOTHER: Elizabeth Marlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Muncy Penna

14 Informant (Address): Mrs Cornelia Mifflin Passapae (daughter) 1727 Bolton St.

15 Filed NOV 30 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923, to Nov. 28, 1923,

that I last saw h[illegible] alive on Nov 25 - 1923

and that death occurred, on the date stated above, at 7 [illegible] m

The CAUSE OF DEATH* was as follows:

Angina Pectoris

About (duration) 1 yrs. X mos X ds.

CONTRIBUTORY (Secondary) [illegible] Cardiac Condition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No ; Autopsy

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

19 23 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Dec 1 - 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (CHARLES F. WOODELL, Successor)

ADDRESS: 109 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT I[illegible]ement of OCCUPA-TION should be carefully supplied. AGE should be stated EXACTL[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&W—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81292

CERTIFICATE OF DEATH.

188-003

D 81292

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David M. Watson

(a) RESIDENCE No. 3813 Fernwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8th 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman 066
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Watson

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Wales
(State or country)

14 Informant John W Hartman
(Address) 3702 Fernwood ave

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. 3 mos. days

CONTRIBUTORY (Secondary) Auto accident

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.
(Coroner.)

Nov. 29th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Balto Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Dec 1 1923

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81293

CERTIFICATE OF DEATH.

179 D 81293

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 613 E 28th (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Virginia Kuszmaul

(a) RESIDENCE NO. 613 E 28th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Lawrence Kuszmaul

6 DATE OF BIRTH (month, day, and year): July 12th 1853

7 AGE — Years: 70 — Months: 9 — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Hy Fortick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Herold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Harry Kuszmaul Jr.

(Address): 1717 Mont Pelier St

15 Filed NOV 30 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28th 1923

17

I HEREBY CERTIFY That I attended deceased from Dec 14th 1922, to Nov 28th 1923.

that I last saw her alive on Nov 28th 1923.

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jno Augustus Reese M. D.

11/28/1923 (Address) 401 E - 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Dec 1st 1923

20 UNDERTAKER: George E Schilling & Sons — ADDRESS: 1124 E Monument St

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81294

74-001 ✓ D 81294

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3219 Dillon St ST. N WARD)

2-FULL NAME Sarah A. Rundlett

(a) RESIDENCE NO. 3219 Dillon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31st 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	3	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town) N. H.
(State or country)

PARENTS

10 NAME OF FATHER Wm Smart

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant India Humphrey
(Address) 2417 Eutaw Pl.

15 Filed NOV 30 1923 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

at once (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Geo. B. Horton, M. D.
Coroner

Nov 29. 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Nov. 30 1923

20 UNDERTAKER H. Sander & Sons — ADDRESS 1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 12-23-21—E.B.R.S.—400 Blks.

D 81295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81295

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2905 Dillon St., 1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James M. Durham

(a) Residence No. 2905 Dillon St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Margaret A. Durham

6-DATE OF BIRTH (month, day and year): April 8, 1838

7-AGE: 85 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Standard Oil Co.

9-BIRTHPLACE (city or town) (State or Country): South Carolina

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14- (Informant) Margaret A. Swayne

(Address) 2905 Dillon St

15- NOV 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923 to Nov 30, 1923

that I last saw h— alive on Nov 29, 1923

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Harvey B. Tillow M. D.

, 19 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Dec 3, 1923

20-UNDERTAKER: H. Sanders & Sons — ADDRESS: 1710 Fleet St.

Spec—12-23-21—E.R.F.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81296

CERTIFICATE OF DEATH.

90 D 81296

1-PLACE OF DEATH

City of BALTIMORE: (No. 2245 Preston Place 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanore Kraft

(a) Residence No. 2245 Preston Place Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 4 1852

7-AGE. 71 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER Jarad Schubert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Mrs Maggie Henry

(Address) 2245 Preston Place

Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 28/1923

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1923 to Nov 28, 1923

that I last saw h. alive on Nov 27 1923

and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis &
Mitral regurgitation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Wilbur F Longwell M. D.

11/28 1923 (Address) 1613 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL. Nov 30 1923

20-UNDERTAKER. John F Benny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-2(—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81297

101-001

CERTIFICATE OF DEATH.

D 81297

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 627 S. 14th St., Highlandtown Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Thomson

(a) Residence No. 627 S. 14th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) Aug 12 1893

7-AGE	If LESS than 1 day,
30 yrs. 2 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rivet Heater

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co

(c) Name of employer: do

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Wm Thomson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Sarah Patterson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

11- (Informant): James Thomson

(Address): 627 S 14 st

15- Filed ..... 192.... ROBERT P. KRAUTER Registrar.

NOV 30 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 28/1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Nov 28, 1923, that I last saw h[illegible] alive on Nov 28, 1923, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What lest confirmed diagnosis? Consolidation of Lungs

(Signed) [illegible] M. D

, 19 (Address) 3015 Eldwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Dec 1, 1923
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Lks.

D 81298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81298

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2420 Orleans St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Foreman

(a) Residence No. 2420 Orleans St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Foreman

6-DATE OF BIRTH (month, day and year) Sept 4/1853

7-AGE. 70 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Employee

(b) General nature of industry, business, or establishment in which employed (or employer)..... P.R.R. 73

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Brooklyn New York

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Mrs Elizabeth Foreman

(Address) 2420 Orleans st

15- Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 28/1923

17- I HEREBY CERTIFY, That I attended deceased from Nov - 6 - 1923 to Nov 28 - 1923

that I last saw h.— alive on Nov 27 1923

and that death occurred, on the date stated above, at 11-30 a. m.

The CAUSE OF DEATH* was as follows:

Vascular Dis. (Mitral Stenosis + Regurg)

(Senile degeneration - attend.)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Compl —

(Duration) yrs. 1/2 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [signature], M. D.

30/11/1923 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Westerm — DATE OF BURIAL, Dec 3, 1923

20-UNDERTAKER, John F Denny — ADDRESS 715 Light st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81299

74-001 D 81299

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3. East Read ST. 11 WARD)

2-FULL NAME Louise Riggs Follis

(a) RESIDENCE NO. 3 - East Read ST., 11 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Follis

6 DATE OF BIRTH (month, day, and year) Jany 29 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Rockville Md.
(State or country)

PARENTS

10 NAME OF FATHER Reuben Riggs

11 BIRTHPLACE OF FATHER (city or town) Rockville
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cemby

13 BIRTHPLACE OF MOTHER (city or town) Rockville
(State or country) Maryland

14 Informant Warren Buehler
(Address) 806 Cathedral St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1923, to Nov 29, 1923, that I last saw h.r alive on Nov 29 1923, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage 1/2 hour
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms of brain hemorrhage

(Signed) Warren Buehler, M. D.

Nov 24, 1923 (Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 12-1 1923

20 UNDERTAKER Henry W Jenkins & Sons Co ADDRESS Mitchell & Cleveland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE. (No. 1112 N. Mount St. 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Dora Schultz

(a) RESIDENCE NO. 3804 Claremont ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life 58 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? 58 yrs. 4 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of late Frederick Schultz

6 DATE OF BIRTH (month, day, and year) July 27/1865 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Arnold Holste

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Bertha (?)

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant John Schultz
(Address) 3804 Claremont St.

15 Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-15-23, 19 . to 11/28, 1923.

that I last saw h alive on 11/28, 1923,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis of Abdomen.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) A. A. Shoopman, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Dec 2 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gall Bladder

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

#6 D 81301

D 81301

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N Bauden ST., 27 WARD)

2-FULL NAME Annie E Martin

(a) RESIDENCE NO. 127 N Bauden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward F Martin

6 DATE OF BIRTH (month, day, and year) Oct 4 76

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	47	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Fultz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Edward F Martin
(Address) 127 N Bauden

15 Filed NOV 30 1923 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1922, to Nov 29, 1923, that I last saw her alive on Nov 28, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

about 2 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 4/23

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Wm Belfrage, M. D.

11/30 1923 (Address) 1319 Eighth St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bur

DATE OF BURIAL Dec 1923

20 UNDERTAKER W M Routson

ADDRESS 223 E N Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 81302

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

D 81302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3441 Reisterstown Rd St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C Adams

(Residence in Baltimore: No. 3441 Reisterstown Rd St.: 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 19, 1853 (Month) (Day) (Year)

7-AGE, 70 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo I Adams

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ciney Rowland

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zella B Adams

(Address) 3441 Reisterstown Rd

15- NOV 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued ..... 19..

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 29, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1923, to Nov 29 1923, that I saw h[illegible] alive on Nov 29 1923 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Chronic Interstitial Nephritis & arteriosclerosis.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary

(Duration) yrs. mos. ds.

(Signed) J H Keech M. D.

11/30/23, 191... (Address) 804 Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonnybor Md — DATE OF BURIAL, Dec 1, 1923.

20-UNDERTAKER H Maurice Rouleon — ADDRESS 2238 W North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81303

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lynch Cove ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 5231 St Charles Ave

(a) RESIDENCE No. 5231 St Charles Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan known 1864

7 AGE: 59 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work.
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Peter Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Gertrude Edwards
(Address) 5231 St Chas Ave.

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Nov 28, 1923,
that I last saw her alive on Nov 27, 1923,
and that death occurred, on the date stated above, at 7A m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles J Wells M. D.

, 19 (Address) 2 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert Cem

DATE OF BURIAL: Nov 30, 1923

20 UNDERTAKER: Peter J Cowan Now Peter J Cowan's

ADDRESS: 901 Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

Karukas ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81304 D 81304

CERTIFICATE OF DEATH.

101-00 N

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1717 Bank St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen Karukas

(a) Residence No. 1717 Bank St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, ✗ Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 2 1923

7-AGE. yrs. 10 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:
10-NAME OF FATHER, James Karukas
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Greece
12-MAIDEN NAME OF MOTHER, Katherine Garafanto
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Greece

14-
(Informant) James Karukas
(Address) 1717 Bank St.

15-
Filed 192
ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29 '23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1923 to Nov 29 1923, that I last saw h[illegible] alive on Nov 25 1923 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Hans Krauter M. D.

, 19 (Address) 325 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 30 1923
20-UNDERTAKER,	ADDRESS
John M. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81305

CERTIFICATE OF DEATH.

90 D 81305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1430 Marshall ST. 23 (WARD)

2-FULL NAME Pauline Wilke Kreiling

(a) RESIDENCE No. 1430 Marshall ST., C WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Kreiling

6 DATE OF BIRTH (month, day, and year) May 8 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	74	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. J. Heim

(Address) 1430 Marshall St

NOV 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16 1923 to Nov 27 1923

that I last saw h alive on Nov 27 1923

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senile Marasmus

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Krauterer M. D.

Nov 30, 1923 (Address) 1430 Marshall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.,

DATE OF BURIAL Nov. 30 1923

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hosp 125 x 129

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. Zenter

(a) RESIDENCE NO. Ellicott City Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? 56 yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Zenter

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk B & O RR

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer B & O RR

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Frederick A Zenter

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) .....

14 Informant Mrs Elizabeth Zenter (Address) Ellicott City Md

15 Filed NOV 30 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-24 1923, to 11-28 1923, that I last saw him alive on 11-28 1923 and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11/27/23

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Hooper MD M. D.

19 (Address) Ellicott City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Cemetery Montgomery Co Md. DATE OF BURIAL Dec 1 1923

20 UNDERTAKER Scott M. Slater ADDRESS Ellicott City

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81307

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-98 81307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Notre Dame Convent

CITY OF BALTIMORE: (No. Aisquith St Westminster ST.) 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Cyrilla Giesel

(a) RESIDENCE. No. Notre Dame Aisquith St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept - 20 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Francis Giesel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sr. M. Dionedes

(Address) Notre Dame Aisquith St

15 Filed Nov 30 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 29 - 1923

17 I HEREBY CERTIFY, That I attended deceased from September, 1923, to Nov 29, 1923, that I last saw her alive on Nov 29, 1923, and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia right side
Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. J. Kirby, M. D.

Nov 29, 1923 (Address) 1106 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	Dec 1 1923
20 UNDERTAKER	ADDRESS
Frank C. Fink	9101 Belair Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Frances Szymanski

HEALTH DEPARTMENT—CITY OF BALTIMORE

1680 Dup 81308

CERTIFICATE OF DEATH.

145-002 D 81308

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Francis Szymanski

(a) RESIDENCE NO. 734 Aliceanna ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 47? Months: Days: If LESS than 1 day, ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Aleczak Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Johns Hopkins Hospital
(Address)

15 Filed NOV 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Nov 25, 1923,

that I last saw him alive on Nov 25, 1923,

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis due to
ruptured uterus — duration 2 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? →

Did an operation precede death? No Date of 11-27-23

Was there an autopsy? No

What test confirmed diagnosis? Operation & Autopsy

(Signed) Warfield M. Firor M. D.

11/28 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 1 1923

UNDERTAKER: Williams Giaisford — ADDRESS: 1118 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Edith L. Butler

Spec.—1-10-21—M&T—1500 Blks.

D 81309

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

46 D 81309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 724 E Preston ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Cahall

(a) RESIDENCE NO. 721 E Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4th 1868

7 AGE: Years 55 Months 1[illegible] Days 24 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER John Porainger

11 BIRTHPLACE OF FATHER (city or town) Baltimore City (State or country)

12 MAIDEN NAME OF MOTHER A. Berig

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Porainger

(Address) 1523 N Washington St

15 NOV 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1923, to Nov 28, 1923.

that I last saw her alive on Nov 27, 1923;

and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

(duration) yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Cancer of Uterus. (duration) yrs. ... mos. 1 yr

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C H Meyer Jr, M. D.

11/29, 1923. (Address) N 34 E Biddle.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem.

DATE OF BURIAL: Dec 2 1923

20 UNDERTAKER: Johnmark Vanderwood

ADDRESS: Reisinstt

Spec.—1-10-21—M&T—1500 Bks.

Skrentny

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81310

CERTIFICATE OF DEATH. 161-001

D 81310

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin J. Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Skrentny

(a) RESIDENCE No. 4301 Belle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24 1923

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Joseph Skrentny

11 BIRTHPLACE OF FATHER (city or town) Emmitsburg (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marion Bolden

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Joseph Skrentny (Address) 4301 Belle ave.

15 Filed NOV 30 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-1923

17

I HEREBY CERTIFY, That I attended deceased from 11-24-, 1923, to 11-30-, 1923,

that I last saw her alive on 11-30-, 1923

and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(7 mnth)

(duration) yrs. mos ½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Parr, M. D.

11/30, 1923 (Address) Franklin J. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus.

DATE OF BURIAL Nov. 30 1923,

20 UNDERTAKER M. J. Sadowski, 705 S Ann

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 81311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81311

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Mc Elderry ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Trader

(a) RESIDENCE NO. 1920 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Trader

6 DATE OF BIRTH (month, day, and year) January 28-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Accomac Co., Va.

PARENTS

10 NAME OF FATHER William Henry Trader

11 BIRTHPLACE OF FATHER (city or town) Accomac Co., (State or country) Va.

12 MAIDEN NAME OF MOTHER Della Chester

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co., (State or country) Va.

14 Informant Della Taylor.

(Address) 1920 Mc Elderry St.

NOV 30 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28 1923

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1920, to November 28, 1923; that I last saw him alive on November 28, 1923, and that death occurred, on the date stated above, at 10:15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Ryland, M. D.

11-28. 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL Dec 1 1923

20 UNDERTAKER John Ellicott

ADDRESS 2008 Allan

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81312

74-009

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N. Lakewood Ave. ST., 6 WARD)

2-FULL NAME Henry Woessner

(a) RESIDENCE NO 433 N. Lakewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanette (Wendler) Woessner

6 DATE OF BIRTH (month, day, and year) Dec 8/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill hand

(b) General nature of industry, business, or establishment in which employed (or employer) n/k

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Matthias Woessner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Dreschler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A. Woessner

(Address) 4ee N. Lakewood Ave

15 Robert P. Harrison,

NOV 30 1923 192 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-Probably cerebral hemorrha

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) unknown (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Wallen, M. D.

(Coroner)

Nov 30 23 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 3 1923

20 UNDERTAKER John Schrier

ADDRESS 2608 Eden

REMOVAL SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81313

CERTIFICATE OF DEATH.

91-001 D 81313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

2-FULL NAME Herman Armstrong

(a) RESIDENCE NO. 508 Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0-10

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown.

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) — N. Carolina

PARENTS

10 NAME OF FATHER Miles Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) B. P. N. Carolina.

12 MAIDEN NAME OF MOTHER Rebecca Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) B. P. N. Carolina.

14 Information Hospital Records. (Address)

15 Filed ..... 19 ..... Registrar

NOV 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Nov 29, 1923, that I last saw him alive on Nov. 29, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured aneurism of abdominal aorta, with extravasation of blood and dissection post peritoneally (duration) Uncertain

CONTRIBUTORY (Secondary) Secondary anaemia. (duration) ..... yrs. 3 mos. 8 days.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of No

Was there an autopsy? yes (Postal).

What test confirmed diagnosis? Autopsy.

(Signed) P. M. Hoffman M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockpoint N C — DATE OF BURIAL 11 Nov 30 1923

20 UNDERTAKER H B Gross — ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Wassermann Negative
Could not account
for the Condition

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81314 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81314

114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1919 E. 32nd St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Caroline Eckels

(a) Residence No. 1919 E. 32nd St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) ✓

5a-If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of Louis Eckels

6-DATE OF BIRTH (month, day and year) Aug 5-1837

7-AGE, 86 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... ore

(c) Name of employer.....

9-BIRTHPLACE (city or town) Germany (State or Country),

PARENTS.

10-NAME OF FATHER, William Lenser

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14- (Informant) Henry F. Eckels

(Address) Hamilton Md

15- Nov 11 Robert P. Harrison, Registrar.

OV 301923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 29-23

17- I HEREBY CERTIFY, That I attended deceased from Nov 18, 1923, to Nov 29-, 1923, that I last saw h.. alive on Nov 28-, 1923, and that death occurred, on the date stated above, at 12 30 G. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) General Exhaustion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Dr. S. A. Brown, M. D.

29-, 1923 (Address) 125 E. Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, Dec 1, 1923

20-UNDERTAKER, Lowe & Heeman ADDRESS 32 & Broad Way

should be carefully supplied. AGE should be stated EXACTLY, even if only a few hours or days. Name of INFORMANT should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81315

154-001 ✓

D 81315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bade

(a) RESIDENCE NO. 418 S. 3rd St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. 6 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 8-1923

7 AGE: Years ..... Months 6 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work: ..... ditto

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Rocco Bade

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nellie Doenges

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Johns Hopkins Hosp

15 Filed ..... 19 ..... Registrar: Robert P. Harrison,

NOV 30 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1923 to Nov 29 1923, that I last saw him alive on Nov 29 1923, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus 2 mos

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? Yes Date of 11-28-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield T. Firor, M. D.

11/29, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Dec 1st 1923

20 UNDERTAKER: Peter Nicolaus — ADDRESS: 2060 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital

Spec.—1-10-21—M&T—1500 Bks.

D 81316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 91-002 D 31316

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. E. Franklin Ave. nr. Boley's Lane ST., 26 WARD)

2-FULL NAME Wm Ezra King Raspeburg

(a) RESIDENCE No. E. Franklin Ave. near Boley's Lane ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice H. King

6 DATE OF BIRTH (month, day, and year) Feb 10-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockraiser do

(b) General nature of industry, business, or establishment in which employed (or employer) Raising hogs & cattle.

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Littlestown, Pa.

PARENTS

10 NAME OF FATHER Jacob King

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Harriet Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Littlestown Pa

14 Informant Alice H. King
(Address) care of John G. Smith Box 358 Reisterstown Md.

Filed NOV 30 1923, 19 Robert P. Harrison, M.D.
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1923. to Nov. 29, 1923.

that I last saw him alive on Nov. 28, 1923,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

11/29, 1923 (Address) 13 Bel Air Rd, Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reservoir, Littlestown Pa. — DATE OF BURIAL Dec 3, 1923

20 UNDERTAKER Wm. Cook, Sr. — ADDRESS Reisterstown Md.

NOV 30 1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81317

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Turner

(a) RESIDENCE NO. 1722 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Virginia Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emma Goodes

(Address) 1722 McCulloh St.

15 NOV 30 1923

16 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1923, to Nov 28, 1923, that I last saw her alive on Nov 28, 1923, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

Marginis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Dotemia

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Fisher, M. D.

11-29-1923 (Address) 1612 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kings Sale Mt Olivet Va

DATE OF BURIAL: Dec 1 1923

20 UNDERTAKER: Brown & Freeland & Schneider

ADDRESS 114 W.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81318

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital St. 7 WARD)

2-FULL NAME Theodore Konon

(a) RESIDENCE NO. Chesco County Boro St. Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred not known. ds. How long in U. S., if of foreign birth? not known. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Annie Konon

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 44 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Machinist 031
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Annie Konon
(Address) Cohasco Pike

NOV 30 1923 .19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from October 30 .1923. to Nov 28 .1923.

that I last saw him alive on Nov 28 .1923.

and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ..... 15 mos ds.

CONTRIBUTORY (Secondary): Hemorrhage from stomach

(duration) ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ..... Ephratary

Did an operation precede death? Date of Oct 10

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical. Autopsy

(Signed) H. M. Kern, M. D.

.19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lebanon Cem. Stones River

DATE OF BURIAL: Dec 1 1923

20 UNDERTAKER: Jos. J. Henson

ADDRESS: 156 N. Eutaw

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81319

HEALTH DEPARTMENT—CITY OF BALTIMORE

STILL BIRTH No. D 81319

CERTIFICATE OF DEATH.

REGISTERED NO. 1623

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 N. Gilmore ST., 16 WARD)

2-FULL NAME Baby Simms

(a) RESIDENCE NO. 1111 N. Gilmore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1923.

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: James Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Samuel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): Robert T. Harrison, JOHNS HOPKINS HOSPITAL

15 Filed NOV 30 1923, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28th, 1923, to Nov. 28, 1923, that I last saw her alive on Nov. 28th, 1923, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxiation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Susanne R. Simms, M. D.

11-28 1923 (Address) 1702 Westwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

(Commissioner Health.)

NOV 30 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Baby found before the
arrival of Physician
was laid in bed
face down

Spec.—1-10-21—M&T—1500 Bks.

D 81320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-09

D 81320

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3527 (ST.) Fairmount Ave (WARD) No

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Vacek

(a) RESIDENCE NO. 3527 ST., Fairmount Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 18-1923

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Boemun (State or country)

PARENTS

10 NAME OF FATHER Joseph Vacek

11 BIRTHPLACE OF FATHER (city or town) Bohm (State or country)

12 MAIDEN NAME OF MOTHER Anna Stepanek

13 BIRTHPLACE OF MOTHER (city or town) .... (State or country) Bohmn

14 Informant Joseph Vacek

(Address) 3527 Fairmount Ave

15 Filed ...., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 23, 19.... to Nov 26 23, 19....

that I last saw h— alive on Nov 26 23, 19....

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) R. Williams Ryan M. D.

, 19 .... (Address) 810 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19....

20 UNDERTAKER ....

ADDRESS ....

Robert P. Harrison, Commissioner Health,

NOV 30 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 30 1923 20915

Cor.—1-12-23—M&T—100 Bks.

D 81321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81321

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1700 N. Caroline St ST., 12 WARD)

2-FULL NAME Clarence G. Unkle

(a) RESIDENCE NO 1700 N CarolineS~t ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Doyott Unkle

6 DATE OF BIRTH (month, day, and year) Arpil 19/187

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 004
(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Clarence Unkle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harrford Co.

14 Informant Wife
(Address) 1700 N. Caroline St

15 NOV 30 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown acute Indigesti

(duration) yrs. mos. ds.

(Signed) J. H. Waller, M. D. (Coroner.)

Nov 30/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12/1 1923

UNDERTAKER George Ruth

ADDRESS 1735 Linford Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81322 — 109-002 — D 81322

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 255 East ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Vasilas

(Residence in Baltimore: No. 255 East St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, (Month) Dec (Day) 28, (Year) 1914

7-AGE, 8 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Nick Vasilas

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Stella Sarvos

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nick Vasilas

(Address) 255 East St.

15- NOV 30 1923, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Nov (Day) 29, (Year) 1923

17. I HEREBY CERTIFY, That I attended deceased from Nov-29-1923, to Nov 29 1923, that I saw him alive on Nov 29 1923, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis Streptococcic infection

Acute articular Rheumatism (Duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Myocarditis acute (Duration) yrs. mos. ? ds.

(Signed) Sid Emanuel M. D.

11-30-, 1923 (Address) 1604 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Dec 1, 191..

20-UNDERTAKER Smith Funeral Home — ADDRESS 1906 Eutaw Pl

Damaso

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Kokta)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81323

CERTIFICATE OF DEATH.

31

D 81323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 962 N Chapel ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barba Grefa Kokta

(a) RESIDENCE NO. 962 N. Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 29

7 AGE — Years: 17 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Candy Packers

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Charles Kokta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Josefa Benadek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Josefina Kokta

(Address) 962 N Chapel St.

15 Robert P. Harrison, Registrar

.19 Burial Permit Clerk.

NOV 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1923, to 11-29, 1923, that I last saw h alive on 11-28, 1923, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 21 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. G. W. Kennard, M. D.

.19 (Address) 708 Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 3 1923

20 UNDERTAKER: Grant Erceb Son — ADDRESS: 1116 Gay St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81324

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Hoard. ST., 21 WARD)

2-FULL NAME Mary Nicolas Bryan

(a) RESIDENCE NO. 1125 Hoard. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Bryan

6 DATE OF BIRTH (month, day, and year) Dec 15 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Grace Bryan

(Address) 1125 Hoard St.

15 Filed ..... 192 .....

Robert P. Harrison,

Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) Jno. Luther Blake M. D.

(Coroner.)

Nov 29, 1923 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 12/1 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem... of OCCU... TION is very important. See instructions on back of certificate.

NOV 30 1923

Spec.—1-10-21—M&T—1500 Blks.

167495 81325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D 81325

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Helen G. Thomas

(a) RESIDENCE NO. Barberton, Ohio WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6d ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 25-23

7 AGE — Years | 5 Months | 5 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER J F. Thomas

11 BIRTHPLACE OF FATHER (city or town) Penn
(State or country)

12 MAIDEN NAME OF MOTHER Iva Fryer

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant Records
(Address) John Hopkins Hosp

15 Filed DEC 1 - 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1923 to Nov 30, 1923.

that I last saw her alive on Nov 26, 1923.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-30-23

Was there an autopsy? Yes

What test confirmed diagnosis? Exam

(Signed) Warfield M. Firor, M. D.

, 19 (Address) Hutt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Akron Ohio — DATE OF BURIAL Nov 30 1923

20 UNDERTAKER Joseph Ahern — ADDRESS 22 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant
Tumor of Brain

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81326

CERTIFICATE OF DEATH.

129 D 81326

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 8 WARD)

2-FULL NAME Charles Winkler

(a) RESIDENCE NO 3159 Lyndale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah P. Winkler

6 DATE OF BIRTH (month, day, and year) Sept 8/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sparrow's Point

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Winkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sophia Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) 3159 Lyndale Ave wife

15 Filed DEC 1 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28/'23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. L. Pullen, M. D.
(Coroner.)

Nov30/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 1/'23

20 UNDERTAKER John A Moran — ADDRESS 5000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81327

CERTIFICATE OF DEATH.

101-001 / D 81327

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Thomas Halligan

(a) RESIDENCE NO. 1329 Stockton St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John M. Halligan
(Address) 329 Stockton St.

15 Robert P. Harrison,
Registrar

16 Burial Permit Cleared.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 19 23

17 I HEREBY CERTIFY, That I attended deceased from 11/24/23, 19..., to 11/30/23, 19..., that I last saw h[illegible] alive on 11/30/23, 19..., and that death occurred, on the date stated above, at 1.55 9 m.

The CAUSE OF DEATH* was as follows:

Rt Lobar Pneumonia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lab & Physical

(Signed) H U Harper M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL 1 Dec / 1923.

20 UNDERTAKER W Leahy & Son.

ADDRESS 1827 N Wall

DEC 1 - 1923

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81328

CERTIFICATE OF DEATH.

74-001

D 81328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Dover st ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Frism—

(a) RESIDENCE NO. 712 Dover st— ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know—

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Adam Campbell

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Caroline Frism—
(Address) 712 Dover st

15 Filed DEC 1 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest or Inquiry.)~~ find that said deceased came to ~~(Inquest or Inquiry.)~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
(duration) a few hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know
(duration) yrs. mos. ds.

(Signed) H H Forsch, M. D.
(Coroner.)

12-1, 192 3 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt auburn cemetery

DATE OF BURIAL Dec 3 1923

20 UNDERTAKER Edward Bryson

ADDRESS 1631 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81329 D 81329

CERTIFICATE OF DEATH.

113

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Bond ST.: WARD)

2-FULL NAME Mrs. Louise Thomas

(a) RESIDENCE. NO. 130 N. Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 8th 1923

7 AGE: Years | Months: 8 | Days: 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Georges Co Md

12 MAIDEN NAME OF MOTHER: Virginia Canty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Wm Thomas

(Address): 130 N. Bond St.

15 Filed DEC 1 - 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1923

17 I HEREBY CERTIFY. That I attended deceased from Nov. 29th, 1923, to Nov. 30th, 1923, that I last saw h er alive on Nov. 29th, 1923, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Neil Bell, M. D.

, 19 (Address) 1217 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 1 1923
20 UNDERTAKER: Edward Bryan	ADDRESS: 631 Calhoun St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81330

CERTIFICATE OF DEATH.

74-091

D 81330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1150 Cleveland ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Morrison

(a) RESIDENCE NO. 1150 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Morrison

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 78. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Dermot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Ellen Kelly

(Address) 1150 Cleveland St.

15 Filed: DEC 1 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923. to Nov 27, 1923.

that I last saw h alive on Nov 27, 1923

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H Campbell M. D.

Dec. 1 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Dec. 1 1923

20 UNDERTAKER: Chas Edward Roy

ADDRESS: Fort Edward, Govanstown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 81331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81331

CERTIFICATE OF DEATH.

X 100-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 Riggs ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME. Marshall Colbert

(a) RESIDENCE. NO. 1432 Riggs ave ST., WARD. Wash. dl. Co.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Colbert

6 DATE OF BIRTH (month, day, and year) Jan 3. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Common Iron Foundry

(c) Name of employer American Iron. Bloom Culpepper Co Va.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Robert Colbert.

11 BIRTHPLACE OF FATHER (city or town) Culpepper (State or country) Court. Va.

12 MAIDEN NAME OF MOTHER Hatty White

13 BIRTHPLACE OF MOTHER (city or town) Culpepper (State or country) Co Va.

14 Informant Robert Colbert.

(Address) 1432 Riggs ave

Filed DEC 1 - 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1923

17

I HEREBY CERTIFY, That I attended deceased from November 23 1923. to Nov 29, 1923.

that I last saw h alive on Nov. 28, 1923.

and that death occurred, on the date stated above, at 2.30 A.M. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sputum

(Signed) William H Wright, M. D.

Nov 29, 1923 Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 2 1923

20 UNDERTAKER Samuel E Whitehead ADDRESS 1436 W Pratt

Spec.—1-10-21—M&T—1500 Bks.

D 81332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81332

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital 3 ST.. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Simmers

(a) RESIDENCE NO. 1407 Eastern Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Robert Simmers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sarah Magern

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norfolk, Va.

14 Informant Municipal Hospital Records
(Address)

15 DEC 1 - 1923 , 19 Robert P. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-28, 1923, to 11-29, 1923,

that I last saw him alive on 11-28, 1923,

and that death occurred, on the date stated above, at 6 5-5 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lob.

(Signed) Claude F. Grace, M. D.

11-29 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cemetery

DATE OF BURIAL Dec. 1 1923

20 UNDERTAKER Geo. L. Ruth

ADDRESS 1735 Harford Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81333

CERTIFICATE OF DEATH.

12 M D 81333

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Moore ST., 17 WARD)

2-FULL NAME Catharine Dixon Hooper

(a) RESIDENCE NO. 508 Moore ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Hooper

6 DATE OF BIRTH (month, day, and year): Oct 8 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Gabriel Kiah

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Sarah Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: James Hooper

(Address): 508 Moore St

15 Filed DEC 1 - 1923 Registrar: Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-28 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-17, 1923, to 11-28, 1923,

that I last saw h. alive on 11-28, 1923

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Urinary

(Signed) J Smelac, M. D.

12-1, 1923 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 12/1/1923

20 UNDERTAKER: Samuel Kennedy

ADDRESS: 578 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81334 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A Kelly Hosp Pl

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Romyn Hitchcock

(a) RESIDENCE NO. Ithaca N. Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hitchcock

6 DATE OF BIRTH (month, day, and year) Dec 1, 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer) professor

(c) Nome of employer

9 BIRTHPLACE (city or town) (State or country) St Louis Mo.

PARENTS

10 NAME OF FATHER Alonza Hitchcock

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Hanna Hollenbeck

13 BIRTHPLACE OF MOTHER (city or town) Greene Co (State or country) N.Y.

14 Informant Emma Hitchcock (Address) Ithaca N. Y.

15 Filed DEC 1 - 1923 Registrar Robert P. Harrison

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov 30, 1923.

that I last saw him alive on Nov 30, 1923

and that death occurred, on the date stated above, at 920 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Grant Edwards M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ithaca New York — DATE OF BURIAL Dec 1 1923

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81335

D 81335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Londen Ave ST., 70 WARD)

2-FULL NAME Katharine Lee Ramies

(a) RESIDENCE NO. 401 Londen Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30 1923

7 AGE — Years — Months — Days — If LESS than 1 day, 18 hrs or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Edward Ramies

11 BIRTHPLACE OF FATHER (city or town) Stafford Co, (State or country) Va.

12 MAIDEN NAME OF MOTHER Katherine Marie Noelke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Katharine Marie Ramies

(Address) 401 Londen Av.

15 Filed DEC 1 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov - 30 - 1923 to Dec 1 - 1923, that I last saw her alive on Nov 30 1923, and that death occurred, on the date stated above, at 2:10 a. m.

The CAUSE OF DEATH* was as follows:

Failure of Foramen Ovale to close

(duration) 18hrs 10min ~~yrs~~ ~~mos~~ ~~ds~~

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Reland, M. D.

12-1-1923 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 12-1-1923

20 UNDERTAKER Dan'l Forbes

ADDRESS 916 Be ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. If the information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 81336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1555 Leslie ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Gibson

(a) RESIDENCE No. 1555 Leslie ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hubbard

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l
(c) Name of employer Mrs. Hiss

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Mrs. Amy Blake.
(Address) 1524 Baker St.

15 Filed DEC 1 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. D'Ennessy, M. D.
(Coroner)

Nov. 29, 1923 (Address) 2807 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Dec 1 1923

20 UNDERTAKER Jas. H. Dennis

ADDRESS 1203 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81337

167-00 D 81337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S Bond ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Moranski

(a) RESIDENCE NO. 415 S Bond ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 30. 1923

7 AGE — Years | Months | Days | If LESS than 1 day ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Moranski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Moranski

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Joseph Moranski
(Address) 415 S Bond St

15 Filed ..... 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Nov 30, 1923.

that I last saw her alive on Nov 30, 1923,

and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J Kynoch M. D.

Nov 31 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 1 1923

20 UNDERTAKER John McGuckin — ADDRESS 1803 Bank St

DEC 1 1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81338

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09

D 81338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1631 N. Vincent St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel May Green

(Residence in Baltimore: No. 1631 N. Vincent St. St.; yrs., mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Nov. 5, 1923 (Month) (Day) (Year)

7-AGE: ..... yrs. ..... mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (Infant)

9-BIRTHPLACE. (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Clarence Green

11-BIRTHPLACE OF FATHER. (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: Alice Davis

13-BIRTHPLACE OF MOTHER. (State or Country): S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Green

(Address) 1631 N. Vincent St.

15- Filed DEC 1 1923 19.. Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 30, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy M. D. (Coroner.)

Dec 1, 1923 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	Dec 1, 1923.
20-UNDERTAKER.	ADDRESS
Mrs. Katie R. Williams	327 Lafayette Ave.

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&C—1500 Bks.

167508 D 81339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 131 D 81339

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hosp.

CITY OF BALTIMORE: (NO. ..... ST., ... WARD) 7

2-FULL NAME Hankle Sawyer.

(a) RESIDENCE NO. Tuskegee, N. Ala. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Jan 17, 1911

7 AGE — Years: 12 — Months: 10 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS

10 NAME OF FATHER: Goldman A. Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Lula Gunge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Records
(Address): Johns Hopkins Hosp

15 Filed: DEC 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1923, to Dec 1, 1923, that I last saw him alive on Dec 1, 1923, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis — Peritonitis
Perinephritic Abscess

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov. 26th

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bushnell N C — DATE OF BURIAL: Dec 1 '23

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 81340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81340

CERTIFICATE OF DEATH.

100-001 D 81340

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 S. Stricker ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gardner L. Johnson

(a) RESIDENCE NO. 31 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia B. Johnson (nee Baxter)

6 DATE OF BIRTH (month, day, and year) November 15, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Mass.

PARENTS

10 NAME OF FATHER Gardner H. Johnson

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza French

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Unknown

14 Informant Julia Johnson

(Address) 31 S. Stricker St.

15 Filed DEC 2 - 1923 ... 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1923

17

I HEREBY CERTIFY, That I attended deceased from November, 1921, to Nov. 29, 1923, that I last saw him alive on Nov. 29th, 1923, and that death occurred, on the date stated above, at 1045 p m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sykesville, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm. H. Shipley M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dana Mass. DATE OF BURIAL Dec 2 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81341

CERTIFICATE OF DEATH.

13 ✓ D 81341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Presstman ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Pulley

(Residence in Baltimore: No. 1416 Presstman St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, June (Month) 10 (Day), 1882 (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John W. Pulley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Pulley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie E. Pulley wife

(Address) 1416 Presstman St.

DEC 2 - 1923 ROBERT R. KRAUTER,
Filed ....., 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 6 weeks ago 191, to Nov. 30 1923, that I saw him alive on Nov. 28 1923, and that death occurred, on the date stated above, at 5-9 a. m.

The CAUSE OF DEATH* was as follows:

Kidney disease (Nephritis)

(Duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. S. Stewart M. D.

Nov. 30, 1923 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec. 2., 1923

20-UNDERTAKER Jos. A. Farrell — ADDRESS 2319 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81342 ✓ D 81342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Colonial Hospital St. 16 Ward) 191

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Frank Baxton

(Residence in Baltimore: No. 1100 N. Monroe St. 27 St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	single

6-DATE OF BIRTH. about 1866
(Month) (Day) (Year)

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Baxton

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Wilmer

(Address) 1100 N. Monroe St.

15. Filed DEC 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 28 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to
Pistol shot wound
of abdomen.
(Duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide
(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D.
(Coroner)

Nov. 30 1923 (Address) 2202 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. Dec 2 1923

20-UNDERTAKER. Jos. A. Farrell — ADDRESS 2317 Monroe St

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81343

CERTIFICATE OF DEATH.

90 D 81343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homeland Ave near Park Heights Av ST., 7 WARD)

2-FULL NAME Adele Counselman Boyd

(a) RESIDENCE NO. Homeland Av near Park Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Geo Boyd

6 DATE OF BIRTH (month, day, and year) July 1st 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Counselman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Roberts

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Holmes Slotter (Address) Homeland Ave

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 , 1923, to Dec 1 , 1923,

that I last saw h alive on Nov 30 , 1923,

and that death occurred, on the date stated above, at 9.10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General nerve + mental dysfunction

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) M Bunnan Koch, M. D.

Dec 1, 1923 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL Dec 3 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81344

HEALTH DEPARTMENT—CITY OF BALTIMORE

1161-002

D 81344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rosenstein

(a) RESIDENCE NO. 812 No Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White Hebrew

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	0	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md. Maryland

PARENTS

10 NAME OF FATHER Sam Rosenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Blanche Rosenbloth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Birditch Russia

14 Informant (Address) Parents 812 N. Calhoun St.

Filed DEC 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1923 to Dec 1, 1923

that I last saw him alive on Dec 1, 1923

and that death occurred, on the date stated above, at 6 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prolonged difficult labor

(duration) yrs. mos. 2 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Forceps Delivery Date of Nov. 25, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Coleman M. D.

12-1-1923 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrem Washington DATE OF BURIAL Dec 3, 1923

20 UNDERTAKER Jack Lewis ADDRESS 1139 E Balto St

Spec.—1-30-21—M&T—1500 Blks.

D 81345

HEALTH DEPARTMENT—CITY OF BALTIMORE

1450 D 81345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Bender.

(a) RESIDENCE NO. 2204 E. Fairmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? 29 yrs. 4 mos. 1 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lewis Bender.

6 DATE OF BIRTH (month, day, and year) July 29 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	29	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Sacks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Sable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Dorothy Sachs (Sister)

(Address) 22 N. Patterson Park Ave.

15 Filed DEC 2 - 1923, 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1923

17

I HEREBY CERTIFY, That I attended deceased from 9^h^5 a.m. Nov. 30, 1923, to 3^h^10 P.m. Nov. 30, 1923,

that I last saw her alive on Nov. 30, 1923,

and that death occurred, on the date stated above, at 3^h^10 P. m.

The CAUSE OF DEATH* was as follows:

Shock & hemorrhage following uterine rupture in trial to start the child. (transverse presentation) (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov 30, 23

Was there an autopsy? no.

What test confirmed diagnosis? Physical exam.

(Signed) John M. F. Bergland M. D.

11/30 1923 (Address) 1 W. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rebecca Rosedale — DATE OF BURIAL Dec 2 1923

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81346 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 81346

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 31 N Luzerne Ave (Ward) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Hinkle

(a) Residence No. 31 N Luzerne Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C Hinkle

6-DATE OF BIRTH (month, day and year) June 2 1865

7-AGE, 7Y yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Worker

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Hinkle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Brunner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mary C Hinkle

(Address) 31 N Luzerne Ave

15- Filed DEC 2 - 1923 ROBERT R. KRAUTER Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 1923, to Nov 29, 1923

that I last saw him alive on Nov. 29, 1923

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas A. Neer, M. D.

11/30/23 (Address) 408 S Pat Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Carmel — DATE OF BURIAL: 12/2/23

UNDERTAKER: R Heumann — ADDRESS: 320 Bond.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81347

CERTIFICATE OF DEATH.

90 D 81347

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3219 Walbrook av. ST., 15 WARD)

2-FULL NAME Oliver J. Hendrix

(a) RESIDENCE NO. 3219 Walbrook av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Katie Pfeil

6 DATE OF BIRTH (month, day, and year) Aug. 11. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) wholesale shoes

(c) Name of employer Keith & Pratt

9 BIRTHPLACE (city or town) (State or country) New Market Pa.

PARENTS

10 NAME OF FATHER Elihu Hendrix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Grizelle Fifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Katie Hendrix
(Address) 3219 Walbrook av

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from about 12 months to Nov 30th 1923, that I last saw him alive on 25th Nov 1923, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) dilation of heart

6 mos (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W F Hill, M. D.

Nov 30 1923 (Address) 1208 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL Dec 3 1923

20 UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81348

CERTIFICATE OF DEATH.

187-007

D 81348

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST. 27 WARD)

2-FULL NAME Louis N. Bradfield Jr.

(a) RESIDENCE NO 4 W. Biddison Ave. (Gardenville) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9j yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Sept. 26/1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis N. Bradfield

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Otto

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Elizabeth Bradfield
(Address) 4 Biddison Ave

15 Filed DEC 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thoracic Hemorrhage- Accident-

(Bursted fly-wheel on circular saw.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. T. Dalton, M. D.
(Coroner.)

Nov 30/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Dec. 2 1923

20 UNDERTAKER Frederick Lassahn & Sons — ADDRESS Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81349

CERTIFICATE OF DEATH.

1299 D 81349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 N Bethel St ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J Robinson

(a) RESIDENCE NO. 1506 N Bethel St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna A Robinson

6 DATE OF BIRTH (month, day, and year): 11/18 1851

7 AGE: Years 72; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tinworker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Frank Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna A Jagessen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Anna A Robinson

(Address) 1506 N Bethel Street

15 Filed DEC 2 - 1923 19.. ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1923, to Nov. 29, 1923.

that I last saw him alive on Nov. 29, 1923

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Chronic Prostatitis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

12/1, 1923 (Address) 1823 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 12/3 1923

UNDERTAKER: George J Ruth

ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 81350

D 81350

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 S. Third St. 16 WARD)

2-FULL NAME August Luigi Federici

(a) RESIDENCE NO. 207 S Third ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 26-22

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto - City

PARENTS

10 NAME OF FATHER Valentino Federici

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosina Fentile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Valentino Federici

Address 207 S. Third St

15 Filed DEC 2 - 1923, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 27, 1923, to Nov 30, 1923, that I last saw him alive on Nov. 30, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) Frank A. Hertz, M. D.

Dec 1, 1923 (Address) 3244 Foster Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery — DATE OF BURIAL 12/3 1923

20 UNDERTAKER George J Ruth 1735 — ADDRESS Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA must be matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1210-1 M&T 1500 Bks.

81351 16777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X45 D 81351

REGISTERED NO.

1 PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Crosson

(a) RESIDENCE No. 2103 Etting St. ST., ... WARD N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates. This information is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Esther Crosson

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 48 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 86

(b) General nature of industry, business, or establishment in which employed (or employer): +

(c) Name of employer: +

9 BIRTHPLACE (city or town) (State or country): ? N. C.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C

12 MAIDEN NAME OF MOTHER: Thamor Boyton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Records

(Address): Johns Hopkins Hosp

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923 to Nov 30, 1923.

that I last saw ~~him~~ alive on Nov 30, 1923.

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma origin undetermined

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcomatosis

(duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hannon, M. D.

Nov 30, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Garysburg N.C.

DATE OF BURIAL: Dec. 2 1923

UNDERTAKER: Joseph A Farrell

ADDRESS: 2317 E. ... St

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 81352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 81352

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Johnson

(a) Residence No. 1526 E. Fayette St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1893

7-AGE: 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Thomas Cox

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14- (Informant) Municipal Hospital Record

(Address)

15- Filed DEC 2 - 1923 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 24 19 23 to November 29 19 23

that I last saw her alive on November 29 19 23

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (- Over)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Fulton M. D

12-1- 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Dec 3 1923

20-UNDERTAKER: Mrs Chas. L. Bailey

ADDRESS: 1421 Jefferson St

R. S.—WHITE PLAINLY WRITE IN INK. should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81353

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1516 ASHLAND AVE. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eldora Cochran

(a) RESIDENCE NO 1516 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clayborne ~~xxxxx~~ Cochran

6 DATE OF BIRTH (month, day, and year) April 15/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	7	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Augustus Pleasant

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Farrow

13 BIRTHPLACE OF MOTHER (city or town) N. Carolina
(State or country)

14 Informant Augustus Pleasant
(Address) 1518 Ashland Ave

15 Filed DEC 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Probably-Acute, history of being sick only six weeks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Walter, M. D.
(Coroner)

Dec 1/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loshy Cemetery — DATE OF BURIAL Dec 3 1923

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1735 Eastlandave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D 81354

REGISTERED NO.

D 81354

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 E. Madison ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry M. Johnson

(a) RESIDENCE NO 1423 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Johnson

6 DATE OF BIRTH (month, day, and year) Aug 15/1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O+O
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Simon Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Susan Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. R.A.Elliott
(Address) 1725 Ashland Ave.

15 Filed . 192 ROBERT R. KRAUTER, Registrar

DEC 2 - 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Collins, M. D.
(Coroner.)

Dec 1 23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence to

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 2 1923

20 UNDERTAKER Mrs. R.A. Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81355

CERTIFICATE OF DEATH.

90 D 81355

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 Argyle Av ST., 17 WARD)

2-FULL NAME Euston Brown

(a) RESIDENCE NO. 1038 Argyle av ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Brown

6 DATE OF BIRTH (month, day, and year) Oct 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Western Md Dairy

9 BIRTHPLACE (city or town) Balto City

(State or country) .....

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Md

12 MAIDEN NAME OF MOTHER Alice Ockamy

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant Mrs Emma Brown

(Address) 1038 Argyle av.

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Nov 30th, 1923.

that I last saw h.... alive on Nov 28th, 19.. .

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Aortic Insufficiency (duration) — yrs. 6 mos. — ds.

CONTRIBUTORY Mitral Regurgitation + (Secondary)

Pulmonary Edema (duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) Edward E Blackwood, M. D.

Nov 30, 1923 (Address) 1329 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn. DATE OF BURIAL Dec 3rd 1923

20 UNDERTAKER Leonard E Wright ADDRESS 1364 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81356

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD) 17

2-FULL NAME Elizabeth Bundy

(a) RESIDENCE NO. 769 N. Wolfe St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE: 13 Years | Months — | Days — | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charlie Bundy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sara Tibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hosp.

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 - 1923 to Nov 29 - 1923.

that I last saw her alive on Nov 29 - 1923.

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Fulminal endocarditis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde A. Bradley, M. D.

19 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 12-3 1923

20 UNDERTAKER David Easton

ADDRESS 916 Cinna Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus viridans

Spec—12-23-21—E.B.R.S.—400 Blks.

Dennis Cupid

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81357 — 129 — D 81357

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 524 Lambert St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dennis Cupid

(a) Residence No. 524 Lambert St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Elizabeth Cupid

6-DATE OF BIRTH (month, day and year) Mar 12 1878

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Auto Truck
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.
10-NAME OF FATHER. Jesse Cupid
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia
12-MAIDEN NAME OF MOTHER. Louise Meyden
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14-(Informant). Elizabeth Cupid
(Address). 524 Lambert St

15-Filed DEC 2 - 1923 ROBERT R. KRAUTER, Clerk. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 30/23

17-I HEREBY CERTIFY, That I attended deceased from Oct 9 1923 to Nov 30 1923

that I last saw h alive on Nov 30 1923

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis
Acute Cardiac Dilatation
(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Cronin M. D.

Dec 1. 1923 (Address) 1504 Mulberry St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Int Woodlawn Cem — DATE OF BURIAL. 12-8 1923

20-UNDERTAKER. Daniel Easton — ADDRESS 516 Gemmar

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 ✓

D 81358

REGISTERED NO. D 81358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 756 George St ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Williams

(a) RESIDENCE NO. 756 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/16/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dayton Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Myrtle Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Myrtle Smith (Address) 756 George St

15 Filed DEC 2 - 1923, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Dec 1st, 1923, that I last saw her alive on Dec 1, 1923, and that death occurred, on the date stated above, at 6.05A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mal Nutrition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Goldman, M. D.

, 19 (Address) 956 Mt Auburn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-3 1923

20 UNDERTAKER Daniel Eastwood

ADDRESS 916 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D 81359

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. If unknown, so state. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Josh Gladfelter

(a) RESIDENCE NO. 3516 Roland ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Mudd Gladfelter

6 DATE OF BIRTH (month, day, and year): Nov. 11-1836

7 AGE: Years 87 Months — Days 18 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): Wm. C. Cooper & Bro

(c) Name of employer: Retired 16 years

9 BIRTHPLACE (city or town) (State or country): York Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Gladfelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Rebecca Kroh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Mrs Rosina G. Stevens

(Address) 3516 Roland Ave

15 Filed DEC 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-29 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-20, 1923, to 11-29, 1923, that I last saw him alive on 11-29, 1923, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-20-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Findings

(Signed) J Norwood Wilson M.D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 3, 1923

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 363 Hall Rd

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81360

CERTIFICATE OF DEATH.

44 D 81360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 Hickory Ave. ST., 13 WARD)

2-FULL NAME Louis C. Deems

(a) RESIDENCE NO. 3422 Hickory Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Elizabeth Deems

6 DATE OF BIRTH (month, day, and year): Oct. 1- 1852

7 AGE: Years 71 Months 2 Days — If LESS than 1 day, ...hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 3 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jacob Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward G. Deems

(Address) 3422 Hickory Ave

15 DEC 2 - 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Dec. 1, 1923

that I last saw h~~e~~r alive on Dec. 1, 1923

and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical sign

(Signed) C. F. Culpepper, M. D.

Dec 2, 1923 (Address) 370 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec. 4 1923

20 UNDERTAKER: Grace H. Burgee — ADDRESS: 303 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE, (No.) ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Wilson King IIIrd.

(a) RESIDENCE NO. 1717 Moreland ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. 10 How long in U. S., if of foreign birth? yrs. mos. 10 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin W. King Jr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Mallebra

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) New York.

14 Informant (Address) Parents. 1717 Moreland Ave

15 Filed DEC 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Dec 1, 1923, that I last saw him alive on Dec 1, 1923, and that death occurred, on the date stated above, at 7.25 P.m.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Thompkins, M. D.

Dec. 1, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery DATE OF BURIAL Dec 3 1923

20 UNDERTAKER: Williams & E... ADDRESS 123 W...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81362

CERTIFICATE OF DEATH.

90 D 81362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Melrose Shore, Cabin Branch, Curtis Bay ST., 25 WARD)

2-FULL NAME William Norris.

(a) RESIDENCE No. Melrose Shore, Cabin Branch Curtis Bay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 12, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Care taker
(b) General nature of industry, business, or establishment in which employed (or employer) Melrose Shore.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Herman Schieck.
(Address) 1422 Marshall st.

15 Filed DEC 2 - 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Dec, 1, 1923 (Address) 1017 S. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 12/3 192 3

20 UNDERTAKER L. Fenn McCully ADDRESS 130 E Front

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81363

CERTIFICATE OF DEATH.

11-0021

D 81363

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hospital 6 St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Wagner

(Residence in Baltimore: No. 127 N Lakewood ave St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-[redacted] MARRIED, [redacted] OR WIDOWED, (Write the word.) Married

6-DATE OF BIRTH, June 10, 1901
(Month) (Day) (Year)

7-AGE, 22 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stock Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis J Wagner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary V Kroger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis J Wagner

(Address) 127 N Lakewood Ave

15-

Filed DEC 2 - 1923 ROBERT R. KRAUTER Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1923, to Dec 1 1923, that I saw him alive on Dec 1 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 12 ds.

(Signed) Manuel L Wagner M. D.

Dec 1, 1923 (Address) 311 S Ellwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 12/5, 1923

20-UNDERTAKER Geo Lembach & Son

ADDRESS 647 Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Kraucunas.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81364

74-09 D 81364

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 716 W. Lombard ST., 4 WARD)

2-FULL NAME Nicodemus Kraucunas

(a) RESIDENCE NO. 716 W. Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49.		3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): not known

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER Nicodemus Kraucunas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant (Address): 716 W. Lombard St Nicodem Kraucunas

15 Filed DEC 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Dec 1, 1923, that I last saw h alive on Nov 30, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

arteriosclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Claud Jones, M. D.

12/1, 19 23 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nicodemus Cemetery — DATE OF BURIAL: Dec 4 1923

20 UNDERTAKER: Charles B. Kuchaucka — ADDRESS: 237 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 81365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81365

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1046 W Fayette St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Ada Dukehart.

(Residence in Baltimore: No. 1046 W Fayette St. ; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, OR DIVORCED. (*Write* the word.) widow

6-DATE OF BIRTH, Oct 31, 1841 (Month) (Day) (Year)

7-AGE. 82 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~none~~
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). York. Pa

PARENTS.

10-NAME OF FATHER, Gideon Bantz.

11-BIRTHPLACE OF FATHER (State or Country). md.

12-MAIDEN NAME OF MOTHER Julia A. Harlman

13-BIRTHPLACE OF MOTHER (State or Country). York Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Ernest Bantz

(Address) 1046 W. Fayette St

15- Filed DEC 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1st, 1923. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1920, to Dec 1, 1923, that I saw h er alive on Nov 29, 1923, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Hy ocarditis

Chronic Endocarditis

(Duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) Elmer B. Freeman M. D.

12/2, 1923 (Address) 412 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery Frederick Md. DATE OF BURIAL, Dec 4, 1923

20-UNDERTAKER George J. Smith. ADDRESS 1532 Hollins St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81366

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frederick Schmeltz

(a) RESIDENCE NO. 928 W. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frederick Schmeltz

6 DATE OF BIRTH (month, day, and year) June 3 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	62	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Wm Schmeltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Frederick Schmeltz

(Address) 928 W. Lexington St.

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5. , 1923 , to Dec. 2 - , 1923 ,

that I last saw him alive on Dec. 2 , 1923 ,

and that death occurred, on the date stated above, at 2:43 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 2 yrs. (4) mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Nov. 7, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. B. Pace, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 19 23
20 UNDERTAKER	ADDRESS
George Schmeltz	Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81367

CERTIFICATE OF DEATH.

X 181-001 D 81367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 738 W. Lexington St. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lampson

(a) RESIDENCE NO. 738 W Lexington St ST., WARD New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lampson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Mr Meadoo

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr D Meadoo

(Address) 33rd & Alameda ave

15 Filed DEC 2 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Unquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Unquest, au-~~ find that said deceased came to ~~topsy or inquiry.)~~ Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas inhalation

Probably (duration) yrs. a few hrs mos. ds.

CONTRIBUTORY (Secondary) Accidental

(duration) yrs. mos. ds.

(Signed) W. F. Gonnella, M. D.
(Coroner.)

12-1, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rensselaer Falls N.Y.	Dec 1923
20 UNDERTAKER W M Routzon	ADDRESS 22 S N Mkt.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 81368

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 919 Myrtle Ave ST., 7 WARD)

2-FULL NAME Louisa Nelson

(a) RESIDENCE NO. 919 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nelson

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C. Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant John Nelson

(Address) 919 Myrtle Ave.

15 Filed DEC 2 - 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Nov 30, 1923,

that I last saw h[illegible] alive on Nov 29, 1923,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Albumen test

(Signed) H C Howard M. D.

12-1, 1923 (Address) 704 W Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillon S. C.

DATE OF BURIAL 12/2 1923

20 UNDERTAKER Samuel A Handley

ADDRESS 928 N Eutaw St

Spec—12-23-21—E.B.P.S.—400 Blks.

D 81369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81369

185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Bingham

(a) Residence No. 1917 Saratoga St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Year 1844

7-AGE, 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, John Bingham.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER, Mary Dingee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Delaware

11- (Informant) Mrs Fred Tyrol

(Address) 1917 N Saratoga St

15- Filed DEC 4 - 1923 19

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/29/23

17- I HEREBY CERTIFY, That I attended deceased from November 10 1923 to November 29 1923

that I last saw her alive on Nov 29 1923,

and that death occurred, on the date stated above, at 7-45 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Fractured Hip

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. LOUDON PARK CEM

DATE OF BURIAL. DEC 3 1923

20-UNDERTAKER. ROBERT BROOKS & SON

ADDRESS Cor CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Fall down steps

Accident

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 81370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 81370

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Harlem Av ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Schroeter

(a) RESIDENCE. No. 2022 Harlem Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK. FACTS MUST BE STATED EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul E. L. Schroeter

6 DATE OF BIRTH (month, day, and year) Sept 28-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Eisermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martha Schroeter

(Address) 2022 Harlem Av

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30- 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6 1923 to Nov. 30 1923, that I last saw her alive on Nov. 30 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chron. Nephritis

" Endo-carditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) anasarca

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conser, M. D.

12/, 1923 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 11/3 23

20 UNDERTAKER W J Tichnor Sons Co

ADDRESS Balto Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 81371

CERTIFICATE OF DEATH.

74 D 81371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3109 Presbury St. ST., 15 WARD)

2-FULL NAME Thomas J. Murphy

(a) RESIDENCE NO. 3109 Presbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine M. Murphy

6 DATE OF BIRTH (month, day, and year) June, 4th., 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McCawley Mfg. Business

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Timothy Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Barry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katherine Micheau Murphy

(Address) 3109 Presbury St.

15 Filed DEC 2 - 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/23

17 I HEREBY CERTIFY, That I attended deceased from Nov 26/23, 19, to Nov 29/23, 19,

that I last saw him alive on Nov 29/23, 1923, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Hemiplegia & Epistaxis

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cystitis & Right Hydronephrosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Mollenberg, M. D.

Nov 30 1923 (Address) 170 Eight

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: 12/3 1923

20 UNDERTAKER: C.F.Evans & Son — ADDRESS: 118 W. Mt.Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81372

CERTIFICATE OF DEATH.

74-001 D 81372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5432 Garrison Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raffele Piersanti.

(a) RESIDENCE No. 5432 Garrison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Piersanti.

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant John Piersanti

(Address) 5732 Garrison Ave

Filed DEC 2 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1923, to Nov. 30, 1923, that I last saw him alive on Nov. 30, 1923, and that death occurred, on the date stated above, at 12 P.m.

The CAUSE OF DEATH* was as follows:

Paralysis:-

Hardening of Arteries

Centrale —

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. N. Buckley, M. D.

, 19 (Address) 126 W Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 3 1923

20 UNDERTAKER John Zellerich — ADDRESS 2608 Eastern

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81373

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3236 Barclay St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Deaver

(a) Residence No. 3236 Barclay St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Deaver

6-DATE OF BIRTH (month, day and year) Dec. 6, 1867

7-AGE. 55 yrs. 9 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Robt Bayer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Ethel L. Deaver

(Address) 3236 Barclay St

15- DEC 3 - 1923 Registrar.

ROBERT B. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923 to Nov 30, 1923

that I last saw h. alive on Nov 30, 1923

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Instantaneous

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) Abt 18 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Thumel M. D.

Dec 2, 1923 (Address) 1334 - 20 W. Cen

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cemetery — DATE OF BURIAL. Dec 3, 1923

20-UNDERTAKER, Mrs R. C. Elliott — ADDRESS 172 Westlander

N. B.—WRITE PLAINLY, WITH INK. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81374

CERTIFICATE OF DEATH.

161-001 D 81374

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 121 Prospect Av ST., 13 WARD)

2-FULL NAME Irving Manes

(a) RESIDENCE NO. 121 Prospect Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Edward Manes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Augusta Gauf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Edward Manes

(Address) 121 Prospect Ave

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 1, 1923, that I last saw h[illegible] alive on Dec 1, 1923, and that death occurred, on the date stated above, at 7.15 m.

The CAUSE OF DEATH* was as follows:

Premature birth, seven months. Asphyxia

13 hrs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical condition

(Signed) R. B. Norment M. D.

Dec. 3, 1923 (Address) 8347 Chelsea Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL Dec 3 1923

20 UNDERTAKER A S Marshall — ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81375

100-001 D 81375

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, 18 WARD)

2-FULL NAME Les Brannock.

(a) RESIDENCE NO. 929 Hollins St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 12, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	3	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Carleton Brannock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Megary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Record.

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/23 .19

17 I HEREBY CERTIFY, That I attended deceased from 11/27/23, 19 ....., to 12/1/23, 19 .....

that I last saw him alive on 12/1/23, 19 .....

and that death occurred, on the date stated above, at 11.35 m.

The CAUSE OF DEATH* was as follows:

Septic meningitis

?
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia — Otitis media Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) K. V. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Dec 3 1923
20 UNDERTAKER Keyser & Son	ADDRESS 9 or Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81376
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Washington Blvd. ST., 21 WARD)

2-FULL NAME Alexander Schwarzenbach

(a) RESIDENCE NO. 1235 Washington Blvd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie T. Schwarzenbach

6 DATE OF BIRTH (month, day, and year) Oct 24, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Elec. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Charles E. Schwarzenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Kemmler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sadie T. Schwarzenbach
(Address) 1235 Washington Blvd

15 Filed DEC 3 - 1923 ROBERT R. KRAUSE, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1923, to Nov 30, 1923, that I last saw h... alive on 11/29/23, 1923, and that death occurred, on the date stated above, at 2.45a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/1, 1923 (Address) 5[illegible] Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Dec 3, 1923

20 UNDERTAKER Mr & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81377

CERTIFICATE OF DEATH.

74-001

D 81377

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Linwood Ave. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James K. Rimby

(a) RESIDENCE NO. 140 N. Linwood Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Rimby

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Letter Carrier

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas B. Rimby

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Rachael Shaw

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) New Jersey

14 Informant Matilda Rimby
(Address) 140 N. Linwood Ave.

15 Filed Dec 3 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Dec 1, 1923.

that I last saw h/m alive on Dec 1, 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Atheroma

from history (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. F. Cheshire, M. D.

12 2, 1923 (Address) 3100 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec. 4, 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway,

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81378

CERTIFICATE OF DEATH.

127 D 81378

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 513 E. 35th St.; 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Diven

(a) RESIDENCE. No. 513 E. 35th St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph L. Diven

6 DATE OF BIRTH (month, day, and year) Dec 9 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
35 Yrs	36	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry E. Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Twitty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph L. Diven

(Address) 513 E. 35th St.

Filed DEC 3 - 1923 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1923, to Dec 1, 1923

that I last saw her alive on Dec 1, 1923

and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Pancreatitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Brown MD, M. D.

12/3 1923 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec 4th 1923
20 UNDERTAKER	ADDRESS
M. Joseph Sypes	600 W Northern

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81379

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. D 81379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Parkin ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Abromaitis

(a) RESIDENCE. NO. 41 Parkin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 60 Years | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coat tailor

(b) General nature of industry, business, or establishment(in which employed (or employer)

(c) Name of employer

880

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Andrew. Abromaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Annie Kubilus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Anthony Abromaitis (Address): 614 E. Balto. St.

15 Filed DEC 3 - 1923 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1923. to Dec 1, 1923. that I last saw him alive on Nov. 30, 1923. and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ? yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness M. D.

19 (Address) 650 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. | DATE OF BURIAL: Dec. 4 '23

20 UNDERTAKER: John Krebiankus | ADDRESS: 425 S. Paca St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81380

CERTIFICATE OF DEATH.

38 D 81380

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Hair.

(a) RESIDENCE NO. 2453 Francis St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Hair

6 DATE OF BIRTH (month, day, and year) 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work United R R

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith 006

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Lucian Hair

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2/23 19

17 I HEREBY CERTIFY, That I attended deceased from 12/1/23, 19, to 12/2/23, 19,

that I last saw ~~h~~ alive on 12/2/23, 19,

and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows:

Ruptured Aorta
Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) N. W. Dolley M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Dec 5 1923

20 UNDERTAKER Ebenezer Thorson ADDRESS 3617 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Suicide

Spec.—1-10-21—M&T—1500 Bks.

D 81381

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 81381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 N. Bond ST., 8 — WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Spence

(a) RESIDENCE NO. 1121 N. Bond ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles B. Spence

6 DATE OF BIRTH (month, day, and year): 10/7/1875

7 AGE — Years: 48 — Months: 1 — Days: 24 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md.

PARENTS

10 NAME OF FATHER: James W. Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Emma Skillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Mr Charles B Spence 1121 N. Bond St

15 Filed DEC 2 - 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1 — 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26 — 1919, to Dec. 1 — 1923, that I last saw her alive on " 1 — 1923, and that death occurred, on the date stated above, at 12.12 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of recto — vaginal septum

(duration) 4 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Extension into abdominal cavity (duration) 3 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of Received [radium treatment

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Edwin R. Fenby, M. D.

12/1/1923 (Address) 1223 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 4 1923

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

Spec. 1-10-21 R&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16788

D 81382

CERTIFICATE OF DEATH.

X113 D 81382

1-PLACE OF DEATH Johns Hopkins Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7 WARD)

2-FULL NAME Thelma Marian Brodowski

(a) RESIDENCE NO. Brafton Ave ST. Fav Lawn Md. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Aug 29, 1923

7 AGE — Years: — Months: 3 Days: 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): #

(c) Name of employer: #

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Brodowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Marion Lefkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records Johns Hopkins Hosp

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923 to Dec 1, 1923.

that I last saw her alive on Dec 1, 1923.

and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (not dysentery)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Poech M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Dec 3 1923

20 UNDERTAKER: H. Sander Sons ADDRESS: 710 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81383

CERTIFICATE OF DEATH.

90 D 81383

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 N. Broadway St., 7 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. C. Horn

(a) Residence No. 904 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Horn

6-DATE OF BIRTH (month, day and year) Aug 22/1842

7-AGE. 81 yrs. 3 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER Christian Barth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Kraft

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn

14- (Informant) Thomas M. Barth

(Address) 904 N. ~~Bond~~ Broadway St

15- Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 1 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to Dec 1, 1923,

that I last saw her alive on Dec 1, 1923,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Senility age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj F. Phillips, M. D.

Dec 2. 1923 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem

DATE OF BURIAL. Dec 4 1923

20-UNDERTAKER. Chas E. Franck

ADDRESS 802 Madison Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-19-21—M&T—1500 Bks.

81384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81384

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gilman Apts Calvert & 31 ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Haslup

(a) RESIDENCE No. Gilman Apts. Calvert & 31 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5- 1882

7 AGE — Years: 41 — Months: 2 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md =

PARENTS

10 NAME OF FATHER: Rev. J. Sil. Haslup

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md. =

12 MAIDEN NAME OF MOTHER: Mary Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md.

14 Informant: Mary R. Haslup

(Address) Gilman Apts

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 = 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1923, to Dec 1 1923,

that I last saw h alive on Dec 1st 1923,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Cardio-nephritis disease

Chronic Valvular disease with decompensation

Acute nephritis Secondary to above disease

Heart condition (duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J. Watson, M. D.

Dec 3, 1923 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec. 3 — 1923

20 UNDERTAKER: Chas O Mitchell — ADDRESS: 1201 W Fayette St =

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK REQUIRES NO ERASURES. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81385 X46 D 81385

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., WARD)

2-FULL NAME Mrs. Carrie Bender.

(a) RESIDENCE NO. 5815 Ryspeng ST., WARD Pittsburg, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Charles F. Bender

6 DATE OF BIRTH (month, day, and year) Oct 23, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Kerr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Kusteer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Charles F. Bender
(Address) 5815 Ryspeng St. Pittsburg

15 Filed DEC 3 - 1923 ROBERT R. KRAMER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to Dec. 2, 1923.

That I last saw her alive on Dec. 2, 1923,

and that death occurred, on the date stated above, at 12.35 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri with metastasis to abdomen

(duration) yrs. 6 mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Repeated examinations

(Signed) Robert E. Schnitker M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Cemetery — DATE OF BURIAL Dec 1923

20 UNDERTAKER George J. Smith — ADDRESS 153 L Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. mation should be stated EXACTLY.

Spec.—1-10-21—M&T—1500 Bks.

Ariama Patterson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81386

CERTIFICATE OF DEATH.

118 D 001 81386

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hamilton Hospital ST. ..... WARD 20)

2-FULL NAME Ariama Patterson aged

(a) RESIDENCE NO. Methodist Home for the ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22/1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Patterson

11 BIRTHPLACE OF FATHER (city or town) Cecil Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J Frickman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Etta Bradley
(Address) 4011 Fairview Ave

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Dec 3, 1923, that I last saw h[illegible] alive on Dec 3, 1923, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows—

Thrombosis of 2d Metatarsal Artery

(duration) yrs. ..... mos 2 ds

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Methodist Home

Did an operation precede death? Yes Date of Dec 2/23

Was there an autopsy? No

What test confirmed diagnosis? Vision

(Signed) Chas. Fellows, M. D.

12/3, 1923 (Address) Hamilton Station

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Dec 6 1923
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. AGE should be stated EXACTLY. mation should be

Spec.—1-10-21 M&T 1500 Blks.

D 81387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 81387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1902 Braddish Ave ST. 15 WARD)

2-FULL NAME Mollie Tipton

(a) RESIDENCE NO. 1902 Braddish Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Alfred Tipton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Sarah E. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Thomas J. Tipton

(Address) 1902 Braddish Av.

15 Filed DEC 3 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923, to Dec. 2, 1923.

that I last saw h[illegible] alive on Dec 1, 1923,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam. of sputum

(Signed) Reuben F. Steelman M. D.

19 (Address) 6 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Dec 5 1923

20 UNDERTAKER E. Schloman & Son ADDRESS 1034 Fremont Av

E.B.R.S.—400 Blks.

81388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81388
Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No.) 917 Russell St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Weston.

(a) Residence No. 917 Russell St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Pauline Weston

6-DATE OF BIRTH (month, day and year) June 17-1893

7-AGE. 30 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter Helper
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS

10-NAME OF FATHER. Frederick Van Weston

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Louisa Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-(Informant) Pauline E. Weston
(Address) 917 Russell St

15- DEC 3 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 1 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1923 to Dec 1923, that I last saw him alive on Nov 30 1923, and that death occurred, on the date stated above, at 1:25 A m.

The CAUSE OF DEATH* was as follows: Laryngeal T.B.

(Duration) 4 mos

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) John [illegible] M. D.
(Address) 11 Newton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park. DATE OF BURIAL, Dec. 3, 1923

20-UNDERTAKER E. T. Bolander 115 ADDRESS E West St

ROBERT P. KRAUSER
Registrar

N. B.—WRITE LEGIBLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. OCCUPATION should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81389

CERTIFICATE OF DEATH.

D 81389

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 S. Curley ST., 1 WARD)

2-FULL NAME Andrew J. Kreamer

(a) RESIDENCE NO. 18 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? 25 yrs. 11 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Julia Kreamer

6 DATE OF BIRTH (month, day, and year) Dec 12/97

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine 86

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Army

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James J. Kreamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Julia Kreamer (Address) 18 S. Curley St.

15 Filed DEC 3 - 1923, 19 ROBERT A. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 - 1923, to Dec 1 - 1923

that I last saw h[illegible] alive on Dec 1 - 1923

and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred H. Herrman M.D.

12-3-23 (Address) 2414 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 12/4 1923

20 UNDERTAKER Pulit Henry — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81390

CERTIFICATE OF DEATH.

74-001

D 81390

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 N. Wolfe ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Von Schlegrell

(a) RESIDENCE NO. 1802 N. Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? 50 yrs. 8 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Geo. Von Schlegrell

6 DATE OF BIRTH (month, day, and year) Mar 6 73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	24	

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Amos J. Raffold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. Von Schlegrell
(Address) 1802 N. Wolfe

15 Filed DEC 3 1923 Registrar

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1923 to Nov 30 1923

that I last saw her alive on Nov 30 1923

and that death occurred, on the date stated above, at 4 54 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 8 mo
Paralysis right side
(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Broke Low femur
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Geo. A. Bladel, M. D.

19 (Address) 143 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Dec 3 1923
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY, and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 81391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 (St.) N Lexington (Ward) 18

2-FULL NAME Sophia E Hiltner

(a) RESIDENCE. No. 810 St., N Lexington Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Hiltner

6 DATE OF BIRTH (month, day, and year): Jan. 20 1858

7 AGE — Years: 65 — Months: 11 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: August Stotzenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John H. Hiltner (Address) 810 N. Lexington St.

15 Filed DEC 3 - 1923 19 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Dec 2, 1923

that I last saw h alive on Dec 2, 1923

and that death occurred, on the date stated above, at 10.15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Aortic Endocarditis
Chr. Hypertrophic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Mitch M. D.

12/2/, 1923 (Address) 215 E Chesapeake ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 5 1923

20 UNDERTAKER: George L. Schwartz — ADDRESS: 2101 Eutaw ave

NAME PLAINLY. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81392

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2017 Wilkens ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Roypen (Roypen)

(a) Residence No. 2017 Wilkens ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Davis Roypen

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 59 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Jack Lewis

(Address) 1439 E Balto St

DEC 3 - 1923 Filed....., 192.. ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 3/23

17- I HEREBY CERTIFY, That I attended deceased from 12-1- 1920 to 12-3- 1923, that I last saw h.. alive on 12-2- 1923 and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Goldberg M. D.

12-3, 1923 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Wash Rd — DATE OF BURIAL, 12/3, 1923

20-UNDERTAKER, Jack Lewis 1439 — ADDRESS E Balto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81393

24-001

CERTIFICATE OF DEATH.

D 81393

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 Main ... Hillsdale ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie R. Frost

(Residence in Baltimore: No. 107 Main St. Hillsdale ... 68 yrs., 5 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, June (Month) 17 (Day), 1855 (Year)

7-AGE, 68 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Alfred Gosnell

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Jane Little

13-BIRTHPLACE OF MOTHER (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosalba Lacy

(Address) Hillsdale ... Baltimore

DEC 3 - 1923

Filed....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 1st (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1923, to Dec 1st 1923, that I saw h[er] alive on Nov 29th 1923, and that death occurred, on the date stated above, at 11.00 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy 2nd Paralysis

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Apoplexy & Paralysis

(Duration) ... yrs. ... mos. 14 ds.

(Signed) Geo. G. Everhart M. D.

12/1....., 1923 (Address) Woodlawn Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, 12/3.., 1923

20-UNDERTAKER William Cook

ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81394

CERTIFICATE OF DEATH.

66 D 81394

1-PLACE OF DEATH Lenering House

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James O'Leary

(a) RESIDENCE No 227 So Mount St St., ... Ward .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Md.

12 MAIDEN NAME OF MOTHER Bridget McCullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William J Klein
(Address) 227 South Mount St

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

Five days (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

(Signed) H. McKelvey, M. D.
Dec 1, 192 3 (Address) 1639 Lamb (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 4 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E Mulb

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HUBERT R. KRAUTER
DEC 3 1923
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 81395

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-01 ✓ D 81395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp ST. 7 WARD)

2-FULL NAME Chas. H. Smith.

(a) RESIDENCE NO. 1424 Carroll St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan-15-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod. maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Gandrie

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cornelia B Conley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Minna Murray

(Address) 1424 Carroll St

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2- 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-20 , 1923 , to 12-2 , 1923 ,

that I last saw h[illegible] alive on 12-2 , 1923

and that death occurred, on the date stated above, at 4 35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tetanus from ectasia

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? 1424 Carroll St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam of Lungs.

(Signed) H W Harper M.D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Dec 5 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE BECOMES PERMANENT RECORD. EACH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 81396

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 S. East Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Tribull

(a) RESIDENCE NO. 704 S. East Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 11 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Tribull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Magdalina Schubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Henry Tribull

(Address): 704 S. East Ave.

15 Filed DEC 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30th 1923.

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Nov 30, 1923

that I last saw him alive on Nov 29, 1923

and that death occurred, on the date stated above, at 5 6, m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Dentition + Bronchitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

12/4, 1923 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Dec. 3 1923.

20 UNDERTAKER: Lilly & Zeiler.

ADDRESS: 1003 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81397 D 81397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 27 WARD)

REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Nellie C. Kennaird

(a) RESIDENCE NO. 695 Gladstone Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs 10 mos ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Raphael A Kennaird

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Raphael A. Kennaird

(Address) 695 Gladstone Ave.

15 Filed DEC 3 - 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923, to Dec. 1, 1923,

that I last saw h[illegible] alive on Dec. 1, 1923,

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos 8? ds.

CONTRIBUTORY (Secondary) Tubo-ovarian abscess, ruptured

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 26, 1923 ??? (Mercy Hospital)

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry U. P. Wilson M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 4 1923
20 UNDERTAKER	**ADDRESS**
John B. Spence	1325 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Groecry;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Gonococcus Infection

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 81398 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 81398

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 McCulloh ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Oscar Williams

(a) RESIDENCE. NO. 1622 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1882

7 AGE — Years: 41 Months: 3 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mount Station Somerset Co Md

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Amelia Whaley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Etta Williams. (Address) 1622 McCulloh St

15 Filed . . 19 . . Registrar

DEC 3 - 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 . 1923. to Dec 2 . 1923., that I last saw him alive on Dec 1 . 1923., and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis - 6
(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) to my knowledge - Nephritis Interstitial (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Wright, M. D.

Dec 3. 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marion Station Somerset Co Md — DATE OF BURIAL: DEC 5 1923

20 UNDERTAKER: Sam'l H. Chase Hon — ADDRESS: 1405 Mosher

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81399 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 ✓

CERTIFICATE OF DEATH. D 81399

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Agnes Hospital St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Jacobs

(a) RESIDENCE NO. 609 Longwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~, or ~~Divorced, (write the~~ word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct 18th 1890

7 AGE: Years — Months 1 Days 13 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs M Jacobs

(Address): 609 Longwood St

15 Filed DEC 3 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923, to Dec 1, 1923,

that I last saw him alive on Dec 1, 1923,

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Streptococcus Infection

Scarlatina yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H S Harper M. D.

, 19 (Address) 56 Eques Roop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12/4/23

20 UNDERTAKER: Geo. Weber's Son — ADDRESS: 2503 Edmondson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchus

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81400

CERTIFICATE OF DEATH.

101-001 ✓ D 81400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1603 N. Bond ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Bouchet

(a) RESIDENCE NO. 1603 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos. A. Bouchet

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto. Md

14 Informant Catherine Wagneman

(Address) 1603 N Bond

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923, to Nov 30, 1923,

that I last saw h— alive on Nov 30, 1923,

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R E Davis M. D.

, 19 (Address) 1509 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 12/4 1923

20 UNDERTAKER Chas. P. Evans & Son

ADDRESS 1180 W. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81401 D 81401

CERTIFICATE OF DEATH.

X 302

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Francis Wilbur Chaney

(a) RESIDENCE NO Laurel, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) June 23/1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Zora Frederline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Zora F. Chaney
(Address) Laurel, Md.

15 Filed DEC 3 - 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2/23 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Purulent Meningitis
Secondary Septic Pneumonia
(Accidentally struck in eye by limb of tree while hunting two weeks prior to death)
(Autopsy by DR. H. J. Maldeis)

(Secondary) mos. ds.

(Signed) J. S. C. Wallis, M. D.
(Coroner)

Dec. 3/23 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem Laurel Md — DATE OF BURIAL 12/3 1923

20 UNDERTAKER E & B. Hale — ADDRESS 1st E West St

Cor.—1-12-23—M&T—100 Blks.

D 81402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1923 D 81402

REGISTERED NO.

1-PLACE OF DEATH 111 So. Register St

CITY OF BALTIMORE (No. 111 ST., 2 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Trazaska

(a) RESIDENCE No 1721 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Trazaska

6 DATE OF BIRTH (month, day, and year) June 18—1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Kazmus Dzudzic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lucia Dzudzic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antonina Dysinske

(Address) 111 S Register St

15 Filed DEC 3 - 1923 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot through Heart
Internal Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.
Coroner.

Dec 2nd, 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 3 1923

20 UNDERTAKER Fred. W Ozazewski ADDRESS Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81403 CERTIFICATE OF DEATH. 38 D 81403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 23 WARD)

2-FULL NAME Susan Garrison

(a) RESIDENCE No. 819 Bevan St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Gross

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabbage Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Municipal Hospital Records.

15 Filed DEC 3 - 1923 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 19 23

17 I HEREBY CERTIFY, That I attended deceased from August 14, 19 22, to November 29 19 23.

that I last saw her alive on November 29, 19 23

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Syphilis

C N S Syphilis

Left Hemiplegia (Residual)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut.

(Signed) Claude A. Heard, M. D.

11-30-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

N. 134

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 81404

1-PLACE OF DEATH D 81404

CITY OF BALTIMORE: (No. Municipal Hospitals ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Moses

(a) RESIDENCE NO. 3803 Foster Ave. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Municipal Hospital Records. JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 3 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from November 24, 1923, to November 29, 1923, that I last saw him alive on November 28, 1923, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Gaulton, M. D.

11-30-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 31405

16b 31405

REGISTERED NO.

1-PLACE OF DEATH D 31405

CITY OF BALTIMORE: (No. 224 N. Vincent ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gertrude Derrecks

(a) RESIDENCE No. 224 N. Vincent St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1923

7 AGE — Years: — Months: — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Thomas Derrecks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Emma Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 3 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I, HEREBY CERTIFY, That I attended deceased from Nov 26, 1923, to Nov 30, 1923,

that I last saw her alive on Nov 30, 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Atypical Junctions

(Signed) J. Elmer Harp M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS DEC 3-192

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81406 — 162 — D 81406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Pearl ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zanti

(a) RESIDENCE NO. 123 N Pearl ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/30/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
				6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Zanti

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Lena Gorska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Louisiana

14 Informant Father
(Address)

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Nov 30, 1923,

that I last saw her alive on Nov 30 1923

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas Pearce, M. D.

11/30, 1923 (Address) St. Vincent's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health. — ADDRESS

Per. Wm. H. WOOSALL

DEC 3 - 1923 — DEC 1 - 192

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See Instructions on back of certificates.

36

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81407

CERTIFICATE OF DEATH.

162 ✓

D 81407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Argyle Ave ST. 17 WARD)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 1021 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

3/6 ✓

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/1/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Hopkins

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 3 - 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 1, 1923,
that I last saw h/m alive on Dec 1, 1923
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atalectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Maternal Syphilis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Wassermann Test

(Signed) Morris Reese, M. D.

12/1, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL: 19 .....

20 UNDERTAKER: Commissioner of Health, per Wm. R. WOODALL

ADDRESS: DEC 1 - 1923

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81408

CERTIFICATE OF DEATH.

66 D 81408

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) ..... (ST.) ..... (WARD) Bay View Hospital

2-FULL NAME Walter E. Nee

(a) RESIDENCE NO. 4529 Eastern Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. + mos. + ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora O. Nee.

6 DATE OF BIRTH (month, day, and year) July 27/1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER John T. Nee

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Alice T. Murphy

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Alice T. Murphy (Daughter)
(Address) 1936 Bank St

15 Filed DEC 3 - 1923 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Dec 7, 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec. 4 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81409

74-002

D 81409

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., ... WARD)

2-FULL NAME Matilda Schlutter

(a) RESIDENCE NO. 130 S. Madeira St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Schlutter

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE — Years: 40 — Months: 9 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS
10 NAME OF FATHER: Adam Paff
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Eliz. Adelsberger
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Johns Hopkins Hospital
(Address)

15 Filed ..... 19 ..... Registrar

DEC 3 - 1923

Buried Dec 5 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Dec 2-, 1923, that I last saw her alive on Dec. 2-, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Rheumatic heart disease
Cerebral embolism

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Walter B. Stewart M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz's Cemetery — DATE OF BURIAL: Dec 5 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Panuska)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31410

CERTIFICATE OF DEATH.

90

REGISTERED No. C

D 31410

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Panuska

(Residence in Baltimore: No. 602 N Castle St.; 1/5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Married

6-DATE OF BIRTH, April 2, 1847
(Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Casimir Panuska

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Kat Brown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Panuska

(Address) 602 N. Castle St

15-

Filed DEC 3 1923, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1923, to Dec 2 1923, that I saw him alive on Dec 1 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) Fred Burnick M. D.

3-25, 191.. (Address) 600 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Dec 7, 1923

20-UNDERTAKER	ADDRESS
Frank Crockton	1106 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81411

CERTIFICATE OF DEATH.

D 81411

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Salvatore

(a) RESIDENCE NO. 1430 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labore 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Salvatore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Aveta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Avada
(Address) Pine Bough

15 Filed DEC 3 1923 192 Robert P. Morrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Shot 4 times in left breast

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B Gorton, M. D.

Dec 3, 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs. ....mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 4 1923

20 UNDERTAKER Wendell Oppel & Son — ADDRESS 378 Hanover

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81412

CERTIFICATE OF DEATH.

101-001 D 81412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Bentalou ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellmine Waterman

(a) RESIDENCE NO. 912 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) ~~WIFE of~~ Annie E. Waterman

6 DATE OF BIRTH (month, day, and year) Nov 26 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Waterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Kaucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie E. Waterman (Address) 912 N. Bentalou St

15 Filed DEC 3 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 26 1923 to Dec 2 1923

that I last saw him alive on Dec 2 1923,

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno. Ehrman, M. D.

Dec 2 1923 (Address) 7 W. 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park DATE OF BURIAL DEC 5 1923

20 UNDERTAKER Geo W. Little ADDRESS 2706 Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 81413

D 81413

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Rennert ST., 4 WARD)

2-FULL NAME Abraham Walter Juvenal

(a) RESIDENCE NO. Hotel Rennert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Abrabraham Juvenal

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Annie Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lillie M. Oliver (Address) 1216 W. Fayette St

15 DEC 3 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1915, to Dec 2 - 1923, that I last saw h[illegible] alive on Dec 2 - 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage.

(duration) Died Suddenly

CONTRIBUTORY (Secondary) Arterio Sclerosis Myocarditis Interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

Dec 3 1923 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec 4 1923

20 UNDERTAKER John O. Mitchell — ADDRESS 1208 W. Fayette St.

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81414

CERTIFICATE OF DEATH.

32 D 81414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Gen Hosp'l (St.) 27 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirl Smith

(a) RESIDENCE NO. 709 Arlington Ave, Govans WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Sgle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 10-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	2	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ballard P Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Helen A Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mother —

15 DEC 3-1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-23

17 I HEREBY CERTIFY, That I attended deceased from 11-30-23, 19 12-2-23, 19 ,

that I last saw h[illegible] alive on 12-2-23, 19 ,

and that death occurred, on the date stated above, at 9.00 P m.

The CAUSE OF DEATH* was as follows:—

I. B. Meningitis

(duration) yrs mos 18 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical & Lab. Evi

(Signed) Jno A Montgomery, M. D.

, 19 (Address) Mt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery Haddonfield N.J. | DATE OF BURIAL: Dec. 4 1923

20 UNDERTAKER: Wm C. Black ADDRESS: 927 N. Broadway

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each question should be carefully answered. If information should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81415

113

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 E Federal ST., 9 WARD)

2-FULL NAME Edith J. McKittrick

(a) RESIDENCE NO. 1214 E Federal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 11 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 15 1923

7 AGE — Years: — Months: 11 Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Luke M McKittrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Detrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Luke M McKittrick (Address): 1214 E Federal St

15 DEC 3 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 1923 to Nov 1 1923, that I last saw her alive on Nov 1 1923 and that death occurred, on the date stated above, at 1 30A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs ..... mos 10 ds.

CONTRIBUTORY (Secondary) Pyelo nephritis

(duration) ..... yrs ..... mos. 11 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Urine analysis

(Signed) Jacob Fushs M. D.

12/3, 1923 (Address) 1823 N Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 4 19 23

20 UNDERTAKER: Wm E Cook — ADDRESS: 502 E Hamilton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81416

HEALTH DEPARTMENT—CITY OF BALTIMORE

81416

CERTIFICATE OF DEATH.

187-07

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis N. Bradfield Sr.

(a) RESIDENCE NO 4 W. Biddison Ave. (Gardenville) ST. WARD

(Usual place nI abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth W. Bradfield

6 DATE OF BIRTH (month, day, and year) Dec. 9/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Bradfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mollie Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md.

14 Informant Elizabeth Bradfield
(Address) 4 W. Biddison Ave.

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas-bacillis infection of right hand-accident on Nov 29, due to bursting of fly-wheel on circular wood saw. (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Rollins, M. D. (Coroner.)

Dec 3/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec. 5 1923
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 3 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81417

CERTIFICATE OF DEATH.

D 81417

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 27 WARD)

2-FULL NAME James A. Greenfield

(a) RESIDENCE NO. Hamilton, Md. ST., Greenfield Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22nd 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Concractor

(b) General nature of industry, business, or establishment in which employed (or employer) 0/6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Phillip C. Greenfield

11 BIRTHPLACE OF FATHER (city or town) Balto. Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan M. Jordan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co (State or country) Maryland

14 Informant Leonard Greenfield (Address) Hamilton Md

15 Filed DEC 3 - 1923 , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 , 1923 , to Dec 1 , 1923 , that I last saw him alive on Dec 1 , 1923 , and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Paralytic Stroke

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Ruptured appendix

Chr. Endocarditis (duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? Hamilton, Md.

Did an operation precede death? Yes Date of Nov. 20, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical evidence - Operation

(Signed) Geo. B. Aybert , M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery — DATE OF BURIAL Dec. 4 1923

20 UNDERTAKER Fredk Lassahn & Sons — ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81418

CERTIFICATE OF DEATH.

21 D 81418

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2948 Cedar Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles G Cerem Jr

(Residence in Baltimore: No. 2948 Cedar Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, Sept 27 (Month) (Day), 1923 (Year)

7-AGE, ... yrs. 2 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles G Cerem

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER, Fillie Joeckel

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fillie Cerem

(Address) 2948 Cedar Ave

15-

Filed ..... Robert P. Harrison, Registrar.

DEC 3 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1923, to Dec 3 1923, that I saw him alive on December 3 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Empyema

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) C. J. Dawes M. D.

12-3-, 1923 (Address) C. J. Dawes

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Dec 4 1923

20-UNDERTAKER Chenoweth Son — ADDRESS Chestnut Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--6-9-19—H. P. Co.—1000 Bks.

D 81419

HEALTH DEPARTMENT—CITY OF BALTIMORE

67-002

D 81419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N. Stricker St.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Thomas Miles

(a) RESIDENCE. No. 1107 N. Stricker ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Miles

6 DATE OF BIRTH (month, day, and year): Aug. 27-1873

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Chemical Foundry

(c) Name of employer: Baltimore Industrial Finishing Company, Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Henry Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER: Eliza Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Mary's Co. Md.

14 Informant: Aunt. (Address) 523 St. Mary's St.

15 Filed DEC 3 - 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 2nd 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29th, 19 23, to Dec 2nd, 19 23, that I last saw h[im] alive on Dec. 2nd, 19 23, and that death occurred, on the date stated above, at 2:25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Suppression of Urine.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. E. Bell, M. D.

, 19 (Address) 1124 Glenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
(W. L.) Loudon	Dec 4 19 23
20 UNDERTAKER: Chas. H. Miles	ADDRESS: 313 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to chemicals at his place of work

Spec.—1-10-21—M&T—1500 Blks.

D 81420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81420

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Knight Alley ST., 16 WARD)

2-FULL NAME Benjamin Gray

(a) RESIDENCE NO. 1101 Knight Alley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co, Md

PARENTS

10 NAME OF FATHER: Benjamin Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mamie Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mamie Gray

(Address) 1101 N. Carey St.

15 Filed ....., 19 .....

Robert F. Harrison, Registrar

Burial Permit Clerk.

DEC 3 - 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 26th, 1923, to Dec 2nd, 1923,

that I last saw him alive on Nov 30th, 1923,

and that death occurred, on the date stated above, at 4.45A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart and Chronic Interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. not known mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-

(Signed) Harry F Brown, M. D.

12/3, 1923 (Address) 136 Freshman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 12/4 1923

20 UNDERTAKER: James A. Reed

ADDRESS: 203 Fremont

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81421

CERTIFICATE OF DEATH.

90 D 81421

REGISTERED NO

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 Myrtle Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Keys

(a) RESIDENCE NO. 1515 Myrtle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Keys

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Bertha Walker
(Address) 1515 Myrtle Ave.

15 Filed ....., 19 Robert E. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Nov. 30, 1923, that I last saw her alive on Nov 30, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

12/1, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Baltimore Co

DATE OF BURIAL 12/4 1923

20 UNDERTAKER Wm. F. Kneeland Co

ADDRESS 1213 Pine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

DEC 3 1923

Spec.—1-10-21—M&T—1500 Bks.

D 81422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81422

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3816 Norwood Ave. West Forest Park ST., 15 WARD)

2-FULL NAME Laura Virginia Davis

(a) RESIDENCE NO. 3816 Norwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) ----------

6 DATE OF BIRTH (month, day, and year) July 29, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John F. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Frances S. Mitchell

(Address) 3816 Norwood Ave.

15 Filed DEC 4 - 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to Dec 7, 1923, that I last saw h alive on Jan 31, 1923, and that death occurred, on the date stated above, at 8,15 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Hypostatic

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Theodore Gash, M. D.

, 19 (Address) 2731 Portwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery, 12/4/23 — DATE OF BURIAL 19

20 UNDERTAKER: H. W. Mears & Son, 805 N. Calvert — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 81423

D 81423

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Seadenhall ST., 22 WARD)

2-FULL NAME Sarah Elizabeth Cornish

(a) RESIDENCE NO. 823 Seadenhall ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Barnes

6 DATE OF BIRTH (month, day, and year) Aug, 22, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Wash + iron

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Cornish

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Sadie Cornish
(Address) 823 Seadenhall

15 Dec 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit D.C.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov, 19, 1923 to Dec, 2, 1923,

that I last saw her alive on Dec, 1, 1923,

and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) Dan Swanelin M. D.

12/3 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec. 5 1923
20 UNDERTAKER John W. Toadvine	ADDRESS 142 W Lee St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 49 D 81424

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1110 Sexton St. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Scott

(a) Residence No. 1110 Sexton St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine S.

6-DATE OF BIRTH (month, day and year) June 13 1898

7-AGE. 25 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Conductor United Rl'wy

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md. (State or Country),

PARENTS

10-NAME OF FATHER. Frederick A. Scott

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Mrs. Catherine Scott

(Address) 1110 Sexton St.

15-

DEC 4 - 1923

16- ROBERT R. KRAUTH Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2, 1923.

I HEREBY CERTIFY, That I attended deceased from Nov 8 1923 to Dec 2 1923

that I last saw h[illegible] alive on Dec 2 1923,

and that death occurred, on the date stated above, at 4p. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of

stark

(Duration) two yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lumar.

(Signed) Raymond G. Flamm M. D

Dec 3, 1923 (Address) Lakeland

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	12/4 1923
20-UNDERTAKER.	ADDRESS
G. F. M. Cully	130 E. Fort

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81425

CERTIFICATE OF DEATH.

71-001 D 81425

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lockman

(a) RESIDENCE NO 2908 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: xxxx

6 DATE OF BIRTH (month, day, and year): Nov 11/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robert Lockman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary E. Luckan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Robt. Lockman
(Address): 2908 Elliott St.

15 DEC 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit issued.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis-"Probably Pneumococcus"

(Autopsy at Hopkins Hospital)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Watson, M. D.
(Coroner.)

Dec 4 23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ev. Lutheran Cem.

DATE OF BURIAL: Dec 4 192

20 UNDERTAKER: H. Lander Sons

ADDRESS: 1710 Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81426

CERTIFICATE OF DEATH.

129 ✓ D 81426

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E Jones

(a) RESIDENCE NO. 517 South Lakewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonzo H Jones

6 DATE OF BIRTH (month, day, and year) April 28-1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
49	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Stockman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Alonzo H Jones (Address) 517 S Lakewood Ave

15 Filed DEC 4 - 1923, 19 ROBERT N. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Dec. 3, 1923, that I last saw h[illegible] alive on Dec. 3, 1923, and that death occurred, on the date stated above, at 5.05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Chronic Nephritis with Hypertension
Apoplexy.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Labr Phy Edgn

(Signed) H W Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Dec 6 1923

20 UNDERTAKER H Sander Sons

ADDRESS 1710 Reads

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81427

CERTIFICATE OF DEATH.

100 D 81427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Bond ST. ST., 6 WARD)

2-FULL NAME Mary Jefferson

(a) RESIDENCE NO 306 ~~Eby~~ N. Bond St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: xxxx

6 DATE OF BIRTH (month, day, and year): Oct 22/1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Alphonso Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Alphonso Jefferson
(Address): 306 N. Bond St.

15 Filed DEC 4 1923 Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Hollis (Coroner.) M. D.

Dec 3/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asBurden Cemetery	Dec 4 1923
20 UNDERTAKER	ADDRESS 631
Edward Bryson	Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-15—H. P. Co.—1000 Blks.

D 81428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81428

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; Chestnut Hill Ave WARD) 9

2-FULL NAME Edward Ray

(a) RESIDENCE. No. St. Elizabeths Home ST., Chestnut Hill Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Major Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Edna Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edna Ray (Address) 1112 N. Chapel St

15 Filed DEC 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3 1923

17 I HEREBY CERTIFY, That I attended deceased from November 16, 1923, to December 2, 1923, that I last saw h~~im~~ alive on December 2, 1923, and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ... yrs. ... mos. 2 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Dec 4, 1923 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 5 1923
20 UNDERTAKER	ADDRESS
Jos F Farrell	1319 Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Mary Taylor

(a) RESIDENCE NO. Boy House Asylum ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid 60

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed DEC 4 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-3 .1923. to 12-1 .1923
that I last saw her alive on 12-1 .1923
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative)
Myocardial Insufficiency

(duration) yrs. 9 mos. (Estimated) ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Thomas ..... M. D.

12-3 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Dist Auter Sec

DATE OF BURIAL 12-5 1923

20 UNDERTAKER Wm Easton

ADDRESS 916 05 ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81430

100-001

D 81430

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., B WARD)

2-FULL NAME James Scott

(a) RESIDENCE NO. 1422 E Bank ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) .....

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed DEC 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h... alive on ....., 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Centura Cemetery — DATE OF BURIAL: Dec 4 1923

20 UNDERTAKER: Edward G Fink — ADDRESS: 1156 Washington Blvd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81431

100-002

D 81431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 white ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel Thornton

(a) RESIDENCE NO. 1900 eyhill ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mabel Thornton

6 DATE OF BIRTH (month, day, and year) Nov 18 1923

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs. or ... min.
✓			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lemuel Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Mabel Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Samuel Thornton

(Address) 1900 N Eutaw St

15 Filed DEC 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to Dec 2, 1923

that I last saw h-y alive on Dec 2, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) ..... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Fred Valentine M. D.

Dec 4, 1923 (Address) 1900 N Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. | DATE OF BURIAL 12-4 1923

20 UNDERTAKER George T. A. Gibson | ADDRESS 1733 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 81432

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 81432

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hosp St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kane

(a) Residence No. 1628 Cole St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1868

7-AGE, 55-0-0 Yrs. 11-27.

yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Kane

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Magegan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Municipal Hospital Records

(Address)

DEC 4 - 1923

ROBERT R. KRAUTER

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2 1923

17- I HEREBY CERTIFY, That I attended deceased from 11-16-23 19.... to Dec 2 19 23

that I last saw him alive on Dec 2 19 23,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Alcohol Sis tools

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Peters

DATE OF BURIAL, Dec 6 1923

20-UNDERTAKER John J. Fields

ADDRESS 1200 W Lombard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Bay View Hospital ST., WARD)

2-FULL NAME William Jones

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 67	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dep't, Eastern Dist

(Address)

15 Filed DEC 4 - 1923 192

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest/autopsy/inquiry) thereon and from the evidence obtained at said (inquest, autopsy, inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Aneurism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) John B. Morton M. D.

(Coroner.)

Dec 27 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

DEC - 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5-8

Cor.—1-12-23—M&T—100 Bks.

D 81434

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

D 81434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse D. Taylor.

(a) RESIDENCE NO 1501 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~(or WIFE of)~~ Roselyn Taylor.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Caulker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bloxom Va.

PARENTS

10 NAME OF FATHER Robert Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER ----- -- ------.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) --------

14 Informant Roselyn Taylor (wife).
(Address) 543 N-13th, St. Philadelphia

15 Filed DEC 4 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27th, 1928. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Poisoning.
Accidental death.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

Nov. 30th. 1928. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
1501 Light St. November 27th, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co. DATE OF BURIAL Dec 4 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Consuella Duncan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81435

CERTIFICATE OF DEATH.

38 D 81435

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1130 McCulloh ST., 11 WARD)

2-FULL NAME Consuella Duncan

(a) RESIDENCE NO. 1130 McCulloh ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 26-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
✓		2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. City

PARENTS

10 NAME OF FATHER George Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mable Tulon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Duncan (Address) 1130 McCulloh St

15 Died DEC 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4th, 1923, to Dec 4th, 1923.

that I last saw h.. alive on Dec. 2d, 1923

and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) Life mos ds.

CONTRIBUTORY (Secondary) Broncho Pneu

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Levi Chis, M. D.

(Address) 52 Woodyear

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bethel Cem

DATE OF BURIAL 12/4 1923

20 UNDERTAKER David J. Hanley

ADDRESS 178 N Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81436

161-001 D 81436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 Forman Ave ST. 20 WARD)

2-FULL NAME Mildred Grumberg

(a) RESIDENCE NO. 54 Forman Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Grumberg

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Johanna Schnell

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mother (Address) 54 Forman Ave

15 Filed DEC 4 - 1923, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 1923, to Dec 2, 1923, that I last saw h[illegible] alive on Dec 2, 1923, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

Premature Birth 7 5 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Cahn M. D.

, 19 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Health Department

DATE OF BURIAL Dec 4 1923

ADDRESS

20 UNDERTAKER Baltimore Cemetery

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81437

CERTIFICATE OF DEATH.

100-001

D 81437

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 School ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Carter

(a) RESIDENCE NO. 721 School ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Carter

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eddie Wade

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country) Md

14 Informant Thomas Carter
(Address) 721 School St

15 Filed DEC 4 - 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Dec 2, 1923, that I last saw him alive on Dec 2, 1923, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) yrs. mos 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr William Frey, M. D.

12/2, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Dec 5th 1923

20 UNDERTAKER Chas W. Chase Son — ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 11ks.

D 81438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81438

CERTIFICATE OF DEATH.

REGISTERED NO. 21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 N. Stricker St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Hardy Henderson

(a) RESIDENCE NO. 1324 N Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	33 yr.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General) Do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Jno. Henderson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Faith

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Eliza Gaskins
(Address) 1324 N. Stricker St.

15 Filed DEC 4 1923 ROBERT R. KRAUTH Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 3, 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Dec 6 1923

20 UNDERTAKER Wm. H. Case Son — ADDRESS 1400 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81439

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 81439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1921 Wilhelm St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gilbert Leister

(a) Residence No. 1921 Wilhelm St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Leister

6-DATE OF BIRTH (month, day and year) Oct 3, 1871

7-AGE, 57 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paper--Hanger

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Israel B.Leister

11-BIRTHPLACE OF FATHER (city or town) Carroll County (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Arm Priester

13-BIRTHPLACE OF MOTHER (city or town) Frederick (State or Country), Maryland

14-

(Informant) Ida B.Leister

(Address) 2245 E.Preston St.

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

DEC 4 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Dec 2, 1923, that I last saw him alive on Dec 1, 1923, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Clus

Cerebro Hypostatic

Clus Infiltration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert C Welch, M. D.

12-3 1923 (Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Dec 5 1923

20-UNDERTAKER: Joseph L Cook — ADDRESS: 1003 W Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81440

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2562 Frederick Avenue St., 20 Ward)

Registered No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Lewis

(a) Residence No. 2562 Frederick Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred E. Lewis

6-DATE OF BIRTH (month, day and year) July 28, 1849

7-AGE,	If LESS than 1 day,
74 yrs. 4 mos. 3 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore County (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Ware

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Houston

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Marie E. Lewis

(Address) 2562 Frederick Ave.

15- Filed DEC 4 1923 ROBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 25, 1923, to Dec 1, 1923, that I last saw h alive on, 19, and that death occurred, on the date stated above, at 9.45 P.m.

The CAUSE OF DEATH* was as follows: Cerebral arteriosclerosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? na

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Asa G. Wessels, M. D.

12-3, 1923 (Address) 2565 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Loudon Park Cem	Dec 4, 23
20-UNDERTAKER, Fox & Cook	ADDRESS 1003 W. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g. sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D 81441 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 31 D 81441

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 W. Baltimore ST., 70 WARD)

2-FULL NAME Mary Etta Schmidt

(a) RESIDENCE NO. 2535 W. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Irvin W. Schmidt

6 DATE OF BIRTH (month, day, and year) March 11, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Collins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Irvin W. Schmidt
(Address) 2535 W. Baltimore St.

DEC 4 - 1923 Filed ..... 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 — 1923 to Dec 1 — 1923.
that I last saw her alive on Nov 30 Dec 1 — 1923,
and that death occurred, on the date stated above, at 4P m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) Chas A Calm, M. D.
, 19 (Address) 2105-N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.
DATE OF BURIAL Dec 4 1923
20 UNDERTAKER Harry H. Witz Co
ADDRESS 531 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81442

CERTIFICATE OF DEATH.

114 D 81442

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 3129 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, gtve its NAME instead of street and number.)

2-FULL NAME William J. Glover

(a) Residence No. 3129 Fleet St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Martha A. Glover

6-DATE OF BIRTH (month, day and year) June 9-1840

7-AGE. 83 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Puddler

(b) General nature of industry, business, or establishment in which employed (or employer). Steel Mill

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER. Thomas Glover

11-BIRTHPLACE OF FATHER (city or town). Baltimore
(State or Country), Md.

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town). Not known
(State or Country),

14- (Informant) Mrs. Chas Nagle

(Address) 3129 Fleet St.

15- Filed DEC 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 1-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th 1923, to Dec 1st, 1923.

that I last saw him alive on Dec 1st 1923

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenlawn

DATE OF BURIAL. Dec 3, 1923

20-UNDERTAKER. Parker & Burke

ADDRESS 1737 Eager

N. B.—WRITE PLAINLY, with ink. Items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Acute Gastro Enteritis

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81443

CERTIFICATE OF DEATH.

D 81443

1-PLACE OF DEATH

Registered No. 1

City of BALTIMORE: (No. 3710 Foster Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Aires

(a) Residence No. Essex Balto., Co., Md. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine E. Aires

6-DATE OF BIRTH (month, day and year) March 10-1891

7-AGE. 32 yrs. 8 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grain Handler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James M. Aires

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Anna Kaufman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Anna Aires

(Address) 3710 Foster ave

15- Filed DEC 4 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 2-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 19 3 to Dec 2 19 23

That I last saw her alive on Dec 1 19 23

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Sarcoma

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Microscopic

What test confirmed diagnosis? Clinical

(Signed) G C Blades M. D

(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL. Dec 6 1923

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager st

N. B. WHITE LABELS, when supplied, should be carefully affixed. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Skin all over body.
Also Liver

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81444

CERTIFICATE OF DEATH.

100-001 D 81444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 808 South Potomac ST., 1 WARD)

2-FULL NAME ANDREW WAWRZYNIAK,

(a) RESIDENCE NO. 808 South Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Widowed,

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Wawrzyniak,

6 DATE OF BIRTH (month, day, and year) Nov. 30-1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	69	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER *** Wawrzyniak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Bronislaus Wawrzyniak.

(Address) 808 S. Potomac St.

15 Filed DEC 4 1923, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923, to Dec 2, 1923,

that I last saw h— alive on Dec 2, 1923,

and that death occurred, on the date stated above, at 5.55 P- m.

The CAUSE OF DEATH* was as follows:

1 Chronic Emphysema —

2 Bronchial Pneumonia

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac failure —

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

, 19 (Address) 125 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem., DATE OF BURIAL Dec. 6th 1923

20 UNDERTAKER W. F. Sadowski, ADDRESS 905 S. Ann St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81445

99-009 D 81445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 3056 Stafford ST., 20 WARD)

2-FULL NAME Thomas G Bowen

(a) RESIDENCE NO. 3056 Stafford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susana Bowen

6 DATE OF BIRTH (month, day, and year) Dec 13. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Green Spring Valley Md.

PARENTS

10 NAME OF FATHER Elias Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sharlotte Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Benjamin Bowen
(Address) 910 Benet Place

15 DEC 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to by death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. S. Crandall, M. D.
(Coroner.)
, 192 (Address) 1532 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Hill Cem: DATE OF BURIAL Dec. 5. 1923

20 UNDERTAKER E. W. Dill. ADDRESS 3109 Fredk. Ave:

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-001 D 81446

D 81446

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 8 WARD)

2-FULL NAME Lemmon W. Webster

(a) RESIDENCE NO. 1928 E. Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13 - 1923

7 AGE — Years — Months 20 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lemmon Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Sehley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 22 1923, to Dec 3, 1923.

that I last saw him alive on Dec 3, 1923,

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Body measurements

(Signed) Casper Fell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Dec 5 1923

20 UNDERTAKER: John Ulrich

ADDRESS: 208 Eden

Spec.—1-10-21—M&T—1500 Blks.

D 81447

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

100-001 D 81447

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2037 E Fayette ST., 6 WARD)

2-FULL NAME Emma V Todd

(a) RESIDENCE NO. 2037 E Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Morton L Todd

6 DATE OF BIRTH (month, day, and year): Feby 17-1838

7 AGE: Years 80 Months 9 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Robt K Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ruth M McCollum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Geo D. Todd

(Address): 2012 E Monument

15 Filed DEC 4 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1923, to Dec 4, 1923,

that I last saw h alive on " " 19.....,

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. ..... mos 2 1 ds.

CONTRIBUTORY (Secondary): Ex Rheumatism

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) Joseph L. Eisenberg, M. D.

Dec 5, 1923 (Address) Joseph L. Eisenberg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Dec 6 1923

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1677 D 81448

CERTIFICATE OF DEATH.

44 D 81448

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 18 WARD)

2-FULL NAME Eliza Parker

(a) RESIDENCE NO. 24 N. Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	37	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Fogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital (Address)

15 DEC 4 - 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2-1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 13-, 1923, to Dec 2-, 1923, that I last saw h[illegible] alive on Dec 2-, 1923 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Nil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov. 11, 1923

Was there an autopsy? No

What test confirmed diagnosis? — X-ray.

(Signed) Cecil H. Bagley M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL Dec 5 1923

20 UNDERTAKER Brown & Freeland — ADDRESS 44 Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 129 D 81449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Josenhans

(a) RESIDENCE NO. Stevens Ave-Middle River St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 4 - 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Josenhans

6 DATE OF BIRTH (month, day, and year): May 30-1866

7 AGE: Years 57 Months 6 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Joseph Josenhans.

11 BIRTHPLACE OF FATHER (city or town) (State or country): German

12 MAIDEN NAME OF MOTHER: Wilhelmina Gerhard,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Josenhans.

(Address) Eastern Ave & Back River Neck

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1923 to Dec. 2 1923.

that I last saw him alive on Dec. 2, 1923,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & T. Exa.

(Signed) J. V. Jozelicki, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Dec. 5 1923

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 S. Wolfe St

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 81450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 81450

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1220 S. Clinton ST.: 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Neugebauer

(a) RESIDENCE. No. 1220 S. Clinton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Neugebauer

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HWK 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER John Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Arthur Neugebauer
(Address) 1220 S. Clinton St

15 Filed ..., 19.. ... Registrar

DEC 4 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1923, to Dec 3rd, 1923, that I last saw her alive on Dec 2nd, 1923, and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Alcohol, Gastritis

(duration) ... yrs. ... mos. 23 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Jones, M. D.

12-4 1923 (Address) 1013 N Gilmore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 5 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81451

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 501 Scott St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Richard Lewis

(a) Residence No.... 501 Scott St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 4 1923

7-AGE,	If LESS than 1 day,
.....yrs.....mos.....ds.	4 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter Lewis

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Wirth

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country), Md.

14- (Informant) Mr Walter Lewis

(Address) 501 Scott St.

15- Filed DEC 4 1923

16- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 4 1923.

17- I HEREBY CERTIFY, That I attended deceased from 12/4/23, 19..., to 12/4/23, 19...

that I last saw him alive on 12/4/23, 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia (4 days)

.....

.....

.....(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) ..... M. D.

12/4, 19 (Address) 501 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Dec 5 1923
St Peters Cem.	
20-UNDERTAKER, Wm G Cowan & Son	ADDRESS 501 Scott St
By W G Cowan	

WHITE PAPER. WRITE PLAINLY. Every question must be answered. If unknown, or if the question does not apply, write "unknown" or "does not apply." Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81452

CERTIFICATE OF DEATH.

161-001 D 81452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 3 WARD)

2-FULL NAME Baby Jones.

(a) RESIDENCE NO. 330 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	If LESS than 1 day, 2 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Benjamin Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Emily Hellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Johns Hopkins Hospital.

15 Filed DEC 4 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923. to Dec 1, 1923.

that I last saw her alive on Dec. 1, 1923.

and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Puerperal Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E E Duncan, M.D.

12/1, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health, DEC 4 - 1923

Per Wm E. WOODALL

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81453

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-006 D 81453

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Spring ST., 5 WARD)

2-FULL NAME Baby Butler

(a) RESIDENCE NO. 209 N. Spring ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				15 hrs.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Alfred Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Crapper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Crapper
(Address) 209 N. Spring

15 Filed DEC 4 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 - 1923

17

I HEREBY CERTIFY, That I attended deceased from 12 - 2 - 1923 to 12 - 3 - 1923, that I last saw her alive on 12 - 3 - 1923, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY —
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Cargile, M. D.

12-3-1923 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, — ADDRESS

DEC 4 - 1923

Wm. S. WOODALL

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81454 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D 81454

CERTIFICATE OF DEATH. 137

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Barbara Ehling

(a) Residence No. Preston & Talbot sts St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Ehling

6-DATE OF BIRTH (month, day and year): 1863

7-AGE: 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Hungary

PARENTS:
10-NAME OF FATHER: John Tiess
11-BIRTHPLACE OF FATHER (city or town) (State or Country):
12-MAIDEN NAME OF MOTHER: Catherine Fowler
13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14- (Informant): Sisters of the Poor
(Address): Preston & Talbot

15- Filed 19?
Robert P. Harrison, Registrar.

DEC 4 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/4/23

17- I HEREBY CERTIFY, That I attended deceased from 11/20 19 23 to 12/4 19 23
that I last saw h alive on 19
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary) Ovarian cyst
Unknown Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Geo. L. Wiss M. D
12/4, 1923 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: Dec 5 1923

20-UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmt Ave

6—WRITE PLAINLY, WITH UNFADING INK. ANSWER EVERY QUESTION. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81455

CERTIFICATE OF DEATH.

74 D 81455

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1702 Byrd ST. 24 WARD)

2-FULL NAME James J Healy

(a) RESIDENCE No. 1702 Byrd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ann Healy

6 DATE OF BIRTH (month, day, and year): May 1861

7 AGE: Years 62 Months 7 Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Elizabeth Handschuh

(Address) 1702 Byrd St

15 Filed DEC 4 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 3, 1923,

that I last saw him alive on Dec 3, 1923,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

Dec 3, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Dec 6 1923

20 UNDERTAKER: H.C. Wiederhold

ADDRESS: 914 Greenmt Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81456

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 Greenmount ST., 10 WARD)

2-FULL NAME Thos J Tierney

(a) RESIDENCE NO. 1047 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Tierney

6 DATE OF BIRTH (month, day, and year): Feb 1861

7 AGE: Years 62 Months 10 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dry goods

(b) General nature of industry, business, or establishment in which employed (or employer): Packer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thos Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Tierney

(Address) 1047 Greenmount Ave

15 Filed DEC 4 1923, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1921, to Dec 2, 1923,

that I last saw h[illegible] alive on " 2, 1923,

and that death occurred, on the date stated above, at ——— m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cooledge M. D.

12/3, 1923 (Address) 24 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 5- 1923

20 UNDERTAKER: H. C. Wiedefeld

ADDRESS: 9 E Greenmount

D 81457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81457

Registered No. C.....

1-PLACE OF DEATH Mercy Hosp

City of BALTIMORE: (No. 110 Lutty Hill Ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred A. Gonce

(Residence in Baltimore: No. 110-1 Lutty Hill Ave St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: May (Month) 1st (Day) 1905 (Year)

7-AGE: 18 yrs. 6 mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telephone Op.
(b) General nature of industry, business, or establishment in which employed (or employer): Operator

9-BIRTHPLACE, (State or Country): Balto md.

PARENTS:

10-NAME OF FATHER: Geo Gonce

11-BIRTHPLACE OF FATHER (State or Country): Balto md

12-MAIDEN NAME OF MOTHER: Bertha Beatrice

13-BIRTHPLACE OF MOTHER, (State or Country): Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Gonce

(Address) 110-1 Lutty Hill Ave

15-

Filed 2-4-1923 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, 2 (Month) 2 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull

Accidentally fell from auto when pedestal struck a rut

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

2-4 192.. (Address) 1639 Eden

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Moriah Cem Towson

DATE OF BURIAL: 2/6/23

20-UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 81458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81458

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N. Eden St. 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tommaso Pistorio

(a) RESIDENCE NO. 1212 N. Eden St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Salvatore Pistorio

6 DATE OF BIRTH (month, day, and year): Nov. 1-1846

7 AGE: Years 86 | Months 1 | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Agostino Mangione

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Margherita Di Bonino

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Antonino Pistorio

(Address) 1212 N. Eden St

15 Filed ..... 19 ..... Registrar

DEC 4 1923

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/1/23 19

17

I HEREBY CERTIFY, That I attended deceased from Nov 20 , 1923 , to Dec 1 , 1923 ,

that I last saw h[illegible] alive on Dec 1 , 1923 ,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

12/3, 1923 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 12/5/23 19

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Hanford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81459

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 81459

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 Ensor St. (ST.) 10 (WARD)

2-FULL NAME Rosario Panzarella

(a) RESIDENCE NO. 810 Ensor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....—.....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Angelo Panzarella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Virginia Re

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Angelo Panzarella
(Address) 810 Ensor St

15 DEC 4 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12- 4- 1923

17 I HEREBY CERTIFY, That I attended deceased from 12- 1- 1923 to 12- 4- 1923, that I last saw him alive on 12- 4 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? 810 Ensor St.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical —

(Signed) S. D. Sumner M. D.

12-4 1923 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemtery	12/4 1923
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81460 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 81460

CERTIFICATE OF DEATH.

Registered No. C. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 Mortimer Ave St., Callaton ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel M. Stevens

(Residence in Baltimore: No. 13 Mortimer Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept (Month) 12 (Day) 1889 (Year)

7-AGE, 34 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 037
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Hugh H. Jones

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Blanche Henshaw

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Stevens

(Address) 13 Mortimer Ave.

15- Filed DEC 4-1923 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

Dec 4 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn	Dec 6 1923
20-UNDERTAKER.	ADDRESS
Wm Flickinger Sons	North Ave

D 81461

HEALTH DEPARTMENT—CITY OF BALTIMORE

80

D 81461

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2635 Penna Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Dorothy V. Batchelor

(Residence in Baltimore: No. 2635 Penna Ave St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	S

6-DATE OF BIRTH. Sept (Month) 4 (Day) 1923 (Year)

7-AGE. ....yrs. 3 mos.....ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. Harold F. Batchelor

11-BIRTHPLACE OF FATHER, (State or Country). City

12-MAIDEN NAME OF MOTHER. Mabel M. Arc

13-BIRTHPLACE OF MOTHER, (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold F. Batchelor

(Address) 2635 Penna Ave

15-

Filed DEC 4-1923 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) [signature] (Coroner.) M. D.

Dec 4 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. Dec 5 1923

20-UNDERTAKER. [illegible] ADDRESS Baltimore

Remarks: Coroner Morrissey

Cause Unknown

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 81462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard Greene ST. 4 WARD)

REGISTERED NO. 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Whitfield Sullivan

(a) RESIDENCE NO. Pikesville Md. ST., WARD Pikesville Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 621

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Univ. Hosp. Records (Address)

15 DEC 4 - 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1923, to Dec. 4, 1923, that I last saw h/M alive on Dec. 4, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystetis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Nov. 28 1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Pathological Findings

(Signed) David R. Hennessy, M. D.

Dec 4, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md. DATE OF BURIAL Dec 6 1923

20 UNDERTAKER Wm Poole Perdue M.B. ADDRESS 034 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81463

CERTIFICATE OF DEATH.

31

D 81463

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Mosher ST.: 16 WARD)

2-FULL NAME Mildred. K obinson

(a) RESIDENCE. NO. 1704 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 16th 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Brookie Robinson

11 BIRTHPLACE OF FATHER (city or town) Essex Co., Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary J. Garrett

13 BIRTHPLACE OF MOTHER (city or town) Middlesex Co., Va.
(State or country)

14 Informant Mrs. Mary J. Lee
(Address) 1704 Mosher St.

15 Filed DEC 5 - 1923 ROBERT R. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27th, 1923, to Dec. 4th, 1923, that I last saw h er alive on Dec. 4th, 1923, and that death occurred, on the date stated above, at 4th A. m.

The CAUSE OF DEATH* was as follows:

Influenza —

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. H. Bell, M. D.

, 19 (Address) 1717 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Dec 5th 1923

20 UNDERTAKER Laurence Lloyd ADDRESS 1 W. Biddle St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec. 1-10-21—M&T—1500 Blks.

D 81464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81464

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Katz

(a) RESIDENCE NO. 2409 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83 ?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work formerly a medical assistant in Europe 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Wm Katz

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Russia

14 Informant Wm Katz
(Address) 812 Ashland Ave.

15 DEC 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-1, 1923 to 12/4, 1923.

that I last saw h alive on 12/4/1923

and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1 wk
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia 2
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. Swoman M. D.

12/4 1923 (Address) Colonial Hosp Resident

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	12/5 1923
20 UNDERTAKER	ADDRESS 127 E Balto St
A Levinson & Bro	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81465

CERTIFICATE OF DEATH.

38 ✓

D 81465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) ST., 7 WARD)

2-FULL NAME Sarah Simon

(a) RESIDENCE NO. 2226 Jefferson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: m

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 19 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machine

(b) General nature of industry, business, or establishment in which employed (or employer): ~~Operator~~ Op

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila Pa

PARENTS

10 NAME OF FATHER: ~~Samuel~~ Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fannie Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto ~~St~~

15 Filed DEC 5 - 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1923

17 Now I HEREBY CERTIFY, That I attended deceased from ~~Dec.~~ 30, 1923, to Dec. 4, 1923, that I last saw h ~~e~~ alive on Dec. 4, 1923, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Hepatic insufficiency with biliary obstruction resulting from arsphenamine in treating syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab

(Signed) Isidor J. Fox, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: 12/5 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81466 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 12/9 D 81466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1735 Belt St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Katherine B. Bauer

(a) Residence No. 1735 Belt St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Bauer

6-DATE OF BIRTH (month, day and year): Feb. 22 1842

7-AGE: 81 yrs. 9 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Md.

PARENTS:
10-NAME OF FATHER: Henry Fischer
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick Md.
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

11-(Informant): Mrs. Bauer
(Address): 1735 Belt St.

15-Filed DEC 5 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 3, 23

17-I HEREBY CERTIFY, That I attended deceased from Nov 21, 1923 to Dec 3, 1923
that I last saw h[er] alive on Dec 3, 1923
and that death occurred, on the date stated above, at 9[10] m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
(Duration) unknown yrs. mos. ds
CONTRIBUTORY (Secondary) Uremia
(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab
(Signed) Wm Stiefler M. D
12/7, 1923 (Address) 1319 Lightner

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: 12/6, 1923

20-UNDERTAKER: I. Few McCully — ADDRESS: 130 E. Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Br (Bensel) 125 S. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81467

99-002

CERTIFICATE OF DEATH.

D 81467

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 417 North Robinson ST., WARD)

2-FULL NAME Charles J. DeHaven

(a) RESIDENCE No. 417 North Robinson ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella DeHaven

6 DATE OF BIRTH (month, day, and year) July 3-1872

7 AGE — Years 51 Months 5 Days — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jesse DeHaven

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Agnes Craig

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md

14 Informant Wm F. DeHaven

(Address) 509 - E. 23rd Street

15 Filed ....., 19 .....

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 3 — 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 28 —, 1923, to DEC - 3 —, 1923, that I last saw h— alive on Dec 3 — 1923 and that death occurred, on the date stated above, at 7.30 P m

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Gen Emphysema

(duration) 1 yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) Contrasyphilis

(duration) .... yrs. .... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

, 19 (Address) 12 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Baltimore Cemetery — DATE OF BURIAL Dec 6 1923

20 UNDERTAKER William Cook — ADDRESS 502 E V

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history
Not Tuberculous

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81468

CERTIFICATE OF DEATH.

111-001

D 81468

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 909 Jordan St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B Hearn

(a) RESIDENCE. NO. 909 Jordan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs 9 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jordan

6 DATE OF BIRTH (month, day, and year) 844 - Feb.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed by City

(b) General nature of industry, business, or establishment in which employed (or employer) Mosquito Dep. of Health

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Hearn

(Address) 909 Jordan St.

15 DEC 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 1923

17 I HEREBY CERTIFY, That I attended deceased from 10 - 6, 1923, to 12 - 3, 1923, that I last saw him alive on 12 - 1, 1923, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) Dr. A. Harris, M. D.

, 19 (Address) 1200 Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 12/5 1923

20 UNDERTAKER: Edward Kessler

ADDRESS: N. Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81469

CERTIFICATE OF DEATH.

Wilmer Brinton
Called to Cristen
74-00 D 81469

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1102 Brentwood ST., 14th WARD)

2-FULL NAME Elizabeth F. Richardson

(a) RESIDENCE No. 1102 Brentwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos Richardson

6 DATE OF BIRTH (month, day, and year): April 15-1834

7 AGE: Years 89; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: Joshua Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Mrs H. Richardson

(Address): 1102 Brentwood

15 Filed DEC 5 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4th. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1923, to Dec 4th, 1923.

that I last saw her alive on Dec 2nd 1923.

and that death occurred, on the date stated above, at 5:40 pm

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senility, Hardening of

many years (duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No. What test confirmed diagnosis? Clinical History

(Signed) Wilmer Brinton M. D.

, 19 (Address) N.W. Cor. Calvert & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York, Pa. M.E. Cemetery

DATE OF BURIAL: 12/6 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 Nor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81470

CERTIFICATE OF DEATH.

12/1 D 81470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 Rochester Place ST.; | WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Parrish

(a) RESIDENCE. No. 100 Rochester Place ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 4-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Parrish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Weir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Jennie Rahlmann
(Address) 100 S Rochester Pl

15 Filed DEC 5 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 Dec. 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to Dec 2nd, 1923 that I last saw h— alive on Dec 1st, 1923 and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John H Carey, M. D.

, 19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 12/5/ 1923

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

D 81471

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002

D 81471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Entah mMenamy 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Downey

(Residence in Baltimore: No. Ent Entah mMenamy St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female white

4-COLOR OR RACE:

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Dec 1 1923 (Month) (Day) (Year)

7-AGE: X yrs. mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS:

10-NAME OF FATHER: Samuel Downey

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Pauline Smith

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Downey

(Address) Entaw at Mt Menamy

15-

DEC 5 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 3 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, au- ...find that said deceased came to ...death topsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH,* was as follows:

Congenital Malformation of Gall

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Congenital

(Duration) yrs. mos. ds.

(Signed) James M Denton M. D. (Coroner)

Dec 4 1923 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: Dec 7 1923

20-UNDERTAKER: Jos Hoffhorger ADDRESS 1416 N Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81472

CERTIFICATE OF DEATH.

D 81472

1-PLACE OF DEATH Johns Hopkins Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. ST., 18 WARD)

2-FULL NAME Howard Calvert

(a) RESIDENCE NO. Florence Crittenton Mission 837 WARD Hollins St

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Oct. 1923

7 AGE — Years: X — Months: 1 — Days: ? — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): ++

(c) Name of employer: ++

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Record

(Address) Johns Hopkins Hosp

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to Nov 27, 1923, that I last saw him alive on Nov 27, 1923, and that death occurred, on the date stated above, at 9 15 A. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (not dysentery)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 837 Hollins St.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. H. Mead, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 3 1923 Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3168

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 81473

REGISTERED NO.

1-PLACE OF DEATH D 81473

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Carter

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address) JOHNS HOPKINS HOSPITAL

DEC 5 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 29, 19 21, to December 1, 19 23,

that I last saw him alive on November 30, 19 23,

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Detumation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronch. Pneumonia

(Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A. Harris, M. D.

12-3-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

DEC 5 - 192

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

D 81474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2218 Cambridge St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Augusta A. Koserske

(a) Residence No. 2218 Cambridge St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Koserske

6-DATE OF BIRTH (month, day and year) March 29-1861

7-AGE. 62 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Amelia Gabrielson
(Address) 2216 Cambridge St.

15- Filed DEC 5 - 1923 192.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from January 7 1923 to December 2nd 1923
that I last saw her alive on December 2nd 1923
and that death occurred, on the date stated above, at 5 20 P. M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
and Cardiac Dropsy
(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dropsy and Exhaustion
(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Austin E. Peck M. D.
, 19 (Address) 1717 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Paul's Cemetery	Dec. 7, 1923

20-UNDERTAKER.	ADDRESS
H. Sander's Sons	1710 Fleet St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Non-Alcoholic

Spec. 1-1921 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81475

CERTIFICATE OF DEATH.

D 81475

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. Wilkens Ave ST. 25 WARD) 74-09

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brother Meinrad Stub

(a) RESIDENCE NO. Mt St Josephs College ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 065

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) " " (State or country)

14 Informant Brother Cantonment (Address) Mt St Josephs College

15 Robert P. Harrison, Registrar

EC 5 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1923, to Dec 4, 1923, that I last saw h— alive on Dec 4, 1923, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (repeated)
Generalized Arteriosclerosis (duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam

(Signed) [illegible] M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 12/6 1923

20 UNDERTAKER F. B. Krance & Son ADDRESS 703 Hanover

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81476

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81476

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 22 WARD)

2-FULL NAME Virginia Dennis

(a) RESIDENCE NO 530 S. Hanover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work no ne
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Durham N.C.

PARENTS

10 NAME OF FATHER Charles Demnis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Virginia- Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Fred A. Krause
(Address) 703 S. Hanover

15 Filed DEC 5 - 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Cerbro-Spinal-Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cain (Coroner.) M. D.

Nov 5/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Durham N. Carolina — DATE OF BURIAL Dec 7 1923

20 UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81477

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: No 3404 Alto Ave. WARD 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard S. Sutton

(a) RESIDENCE. No. 3404 Alto Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Mary S. Sutton

6 DATE OF BIRTH (month, day, and year) Nov 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Post Office

(b) General nature of industry, business, or establishment in which employed (or employer) 504

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth A. Chouteau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary S. Sutton (Address) 3404 Alto Ave

15 Filed DEC 5 - 1923 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

17 I HEREBY CERTIFY, That I attended deceased from November 28, 1923, to December 5, 1923, that I last saw h in alive on December 4, 1923, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arth cardiac dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 618 Audubon Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) G. W. Syphers, M. D.

Dec 5, 1923 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Druid Ridge

DATE OF BURIAL DEC 7 1923

20 UNDERTAKER Geo W Little

ADDRESS 2308 EDMONDSON AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... PA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Joseph A. Schaub

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81478 ✓ D 81478

188-063

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 9 WARD)

2-FULL NAME Jos A. Schaub

(a) RESIDENCE NO. 613 - E. 37th St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Anna Schaub

6 DATE OF BIRTH (month, day, and year) March 3-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	9 -		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos A. Schaub Jr

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mckinon

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Anna Schaub
(Address) 613 E. 37th

15 DEC 5 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & crushed Chest

(duration) 4 hrs. ..... min.

CONTRIBUTORY (Secondary) Struck by Auto truck

(duration) ..... yrs. about ..... m.

(Signed) N X Gonzales, M. D.
(Coroner.)

12-5, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL 12/7 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81479

CERTIFICATE OF DEATH.

21 11-001

D 81479

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 Washington Boulevard St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Catherine Smardon

(a) Residence No. 1427 Washington Boulevard St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Smardon

6-DATE OF BIRTH (month, day and year) Jan. 11, 1854

7-AGE, 69 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore County
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Lauer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa Marshall

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country).

14- (Informant) Daniel E. Collins
(Address) 1427 Washington Boulevard

15- Filed DEC 5 - 1923 19.. Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 5, 1923, that I last saw h alive on March, 1923, and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Grip

(Duration) ....yrs. ....mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Hyland Braun M. D.

12-5-23 (Address) 1227 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, Dec. 8, 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81480 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Bucks Lane St., 28 47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Meeks (Oak Grove Farm)

(a) Residence No. Bucks Lane St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Meeks

6-DATE OF BIRTH (month, day and year) March 9, 1872

7-AGE, 51 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) (at home)

(c) Name of employer.....

9-BIRTHPLACE (city or town)....(State or Country), Delaware

PARENTS.

10-NAME OF FATHER, George Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Anna

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Delaware

14- (Informant) Mrs. Ida Ricard

(Address) Bucks Lane

15- Filed DEC 5-1923, 19.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Dec 5, 1923, that I last saw her alive on Dec 2, 1923, and that death occurred, on the date stated above, at 12.15 (noon) The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry A Bo... M. D.

12-5-, 1923 (Address) 622 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem	Dec. 7th, 1923

20-UNDERTAKER.	ADDRESS
Jacob Book	1003 N. Eutaw St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1002 Hollins Street St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....John A. Sullivan

(a) Residence No. 1002 Hollins Street St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 16, 1881

7-AGE. 42 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Produce Dealer.

(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel Sullivan

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Rose Manning

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Miss Angela Brennan

(Address) 1025 Hollins St.

15- Filed DEC 5 1923 19 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 18, 1923, to December 4, 1923

that I last saw h.. alive on....., 1923,

and that death occurred, on the date stated above, at 12.25 M.

The CAUSE OF DEATH* was as follows:

Sarcoma of inguinal glands

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Rupture of ilia artery

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?..... No

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

12-4, 1923 (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mgr Cathedral Cem	Dec 7, 1923

20-UNDERTAKER. Joseph B Cook ADDRESS 1003 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81482

CERTIFICATE OF DEATH.

74-06 D 81482

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Kirwan

(a) RESIDENCE NO. 1712 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Emma Kirwan

6 DATE OF BIRTH (month, day, and year) Sept 6th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Zebulin Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Hospital Records.

(Address) Lombard and Green Sts.

15 Filed DEC 5 - 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 4, 1923

17 I HEREBY ~~CERTIFY~~. That I attended deceased from DEC 4, 1923, to DEC. 4, 1923, that I last saw him alive on DEC. 4, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Right side of Pons.

(Duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis (duration) Instant dys

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) B. M. Rhodes M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Dec 7th 19 23

20 UNDERTAKER Wm. P. Cook ADDRESS 1003 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unk

Spec.—1-10-21—M&T—1500 Bks.

D 81483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81483

143-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Goldberg

(a) RESIDENCE NO. 2790 W. North ave ST., ... WARD .....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: married

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fannie Kopelinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: M. Goldberg (Address) 2790 W. North ave

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1923, to Dec 5, 1923, that I last saw her alive on Dec 5, 1923, and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Post-operative shock.

(duration) yrs. mos 1 hr.

CONTRIBUTORY (Secondary): Pregnancy, transverse presentation

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 5, 1923

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isidore S. Frey, M. D.

Dec 5, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL 12/6 1923

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1121 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81484

CERTIFICATE OF DEATH.

135

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 9 WARD)

2-FULL NAME Erastus D. Nixon

(a) RESIDENCE NO. aged mens Home Calhoun & Lexington STS. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred many years. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-13-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Formerly in

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Business 045

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Scranton Pa.

PARENTS

10 NAME OF FATHER D. Thos. Nixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. C. E. Nixon (Address) 1925 W. Lexington St

15 Filed DEC 6 - 1923 ROBERT R. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-1923

17

I HEREBY CERTIFY, That I attended deceased from 11-24-, 1923, to 12-5-, 1923, that I last saw him alive on 12-5-, 1923 and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

1 Hypertrophied Prostate

2 Retention of urine

(duration) #1 0 yrs. #2 mos 1 ds.

CONTRIBUTORY (Secondary) Shock following Cystotomy

C.A.C. Imp. (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 11-3-23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. J. Penn, M. D.

12/5/, 1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Presb. Church DATE OF BURIAL Dec 7 1923

20 UNDERTAKER George J. Smith ADDRESS 1331 Hollins St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 81485

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 Edmondson Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Probst

(a) Residence No. 1715 Edmondson Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (~~Write the word.~~) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Elinor Probst

(Address) 1715 Edmondson

DEC 6 - 1923

ROBERT R. KRAMER

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5 1923

17- I HEREBY CERTIFY, That I attended deceased from 1921 to Dec. 5 1923

that I last saw h~~e~~r alive on Dec 4 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Bishop M. D

, 19 (Address) 930 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Dec. 8 1923

20-UNDERTAKER. George J. Smith

ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 81486 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 81486

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 4700 Harford Rd St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Robert Wheeler

(a) Residence No. 4700 Harford Rd St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dora J. Wheeler

6-DATE OF BIRTH (month, day and year) Feb 10 1854

7-AGE. 69 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired 034

(b) General nature of Industry, business, or establishment in which employed (or employer). Grocer

(c) Name of employer.

9-BIRTHPLACE (city or town). Calvert Co (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Wheeler

11-BIRTHPLACE OF FATHER (city or town). St Marys Co (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town). Calvert Co (State or Country), Md

14- (Informant). Dora J. Wheeler Wife

(Address). 4700 Harford Rd

15- FILED DEC 6 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 4 23

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 to Dec 4 1923

that I last saw him alive on Dec 4 1923

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Bright Disease

Uncertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary analysis

(Signed) Jno Dulany Dunn M. D.

, 19 (Address) 330 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Dec 6, 1923

20-UNDERTAKER. John F. Denny

ADDRESS. 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81487

CERTIFICATE OF DEATH.

D 81487

146

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. University Hospital ST. 22 WARD)

2-FULL NAME Evelyn Pritchard

(a) RESIDENCE NO. 1424 W. York ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 23 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Norfolk Va.

PARENTS

10 NAME OF FATHER: Alfred Weeks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eden N.C.

12 MAIDEN NAME OF MOTHER: Lydia Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Hospital Records.

(Address) .....

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 3, 1923, that I last saw her alive on Dec. 3, 1923, and that death occurred, on the date stated above, at 2.08 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Post partum Sepsis

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J A Rothfuss, M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct

DATE OF BURIAL: Dec 6 1923

20 UNDERTAKER: S. H. Brown's Son

ADDRESS: 108 W. Mount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81488

CERTIFICATE OF DEATH.

117 D 81488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Zubavihus

CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 4 WARD)

2-FULL NAME Peter Bubavicle

(a) RESIDENCE NO. 713 W Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Petronella Zubavihus

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Noknow

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Noknw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Noknw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Mrs Zubavihus

(Address) 713 W Lombard Street.

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-2 1923 to 12-4 1923

that I last saw h[illegible] alive on 12-4 1923

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-2-23

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Norwood Wilson M. D.

1923 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 7. 1923

20 UNDERTAKER John Grebliauckas ADDRESS 425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 81489

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 81489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Colvin ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Genovese

(a) RESIDENCE NO. 412 Colvin St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29-1920

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
3		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) East Italy (State or country)

PARENTS

10 NAME OF FATHER Antonino Genovese

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Domenica Curiarre

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Antonino Genovese

(Address) 412 Colvin St

15 Filed DEC 6 - 1923, 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Dec 4, 1923

that I last saw her alive on Dec 4, 1923

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hugo L. DeStefano M. D.

Dec 5, 1923 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetery

DATE OF BURIAL Dec. 6 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 81490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 81490

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Booth ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Helwig

(a) RESIDENCE NO. 2202 Booth ST., WARD

(Usual place of abode) Life

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Helwig

6 DATE OF BIRTH (month, day, and year) Sept 11, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Purnes Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Brass Foundry C'o

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Helwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ---- Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna B. Helwig (Address) 2202 Booth St.

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Dec 3, 1923, that I last saw him alive on Dec 3, 1923, and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W. Jones M. D.

Dec 4 '23 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Dec 6 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 1051 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81491

CERTIFICATE OF DEATH.

38 D 81491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 16 WARD)

2-FULL NAME William Benley

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Providence, R.I.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit District

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1923, to December 2, 1923, that I last saw him alive on December 1, 1923, and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Syphilis - duration?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Autopsy~~, Path.

(Signed) Claude 9. Bruce, M. D.

12-3-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore cemetery — DATE OF BURIAL Dec 6 '23

20 UNDERTAKER Harry H. Weitzel — ADDRESS 1581 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31492

CERTIFICATE OF DEATH.

47 D 81492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp ST., 16 WARD)

2-FULL NAME Mrs Maria Brunow

(a) RESIDENCE NO. 726 Poplargrove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Anthony Brunow

6 DATE OF BIRTH (month, day, and year) Nov 1 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65 yrs.	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs. A. Morris

(Address) 726 Poplar Grove St

15 Filed DEC 6 - 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-29, 1923, to 12-5, 1923,

that I last saw h alive on 12-5-, 1923

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

- due to extension

Malignancy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

Mediastinum (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

1914-1920

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray - Phys Findings

(Signed) H J Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER Josiah Syfer

ADDRESS 1600 W North Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 81493

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-901

D 81493

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Dukeland ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie M. Frazier

(a) RESIDENCE. No. 1806 Dukeland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female.

4 COLOR OR RACE White.

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin C. Frazier

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John H. Moore dec

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Boston N.H.

12 MAIDEN NAME OF MOTHER Jane Spaulding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester N.H.

14 Informant Edwin S. Frazier Son

(Address) 1806 Dukeland Ave. Balto

15 DEC 6 - 1923 19 ROBERT R. KRAUS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 1923 to Dec. 6 1923

that I last saw h.. alive on Dec. 5 - 1923.

and that death occurred, on the date stated above, at 5.00 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Adelmann M. D.

12/6/23 (Address) 2757 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Washington 206

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER Josiah Lyle

ADDRESS 1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81494

CERTIFICATE OF DEATH.

74-001

D 81494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3628 Elm Ave ST. 13 WARD)

2-FULL NAME Sarah C Fanwell

(a) RESIDENCE NO. 3628 Elm Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeremiah Fanwell

6 DATE OF BIRTH (month, day, and year): May 19 1844

7 AGE: Years 79 Months 6 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Harry Fanwell

(Address) 3628 Elm Ave

Filed DEC 6 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 23, to Dec 4, 19 23,

that I last saw h— alive on Dec 3, 19 23

and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

, 19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mays Hampden

DATE OF BURIAL: Dec 6 19 23

20 UNDERTAKER: CHENOWETH & SON

ADDRESS 3617 CHESTNUT AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

81495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81495
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 South Carey ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis Keane

(a) RESIDENCE No. 220 South Carey St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaning Dept.

(b) General nature of industry, business, or establishment in which employed (or employer): Sweeper. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Keane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen J. Curtis Keane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Mary R. Keane
(Address) 220 South Carey St.

DEC 6 - 1923 Filed 19

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 5, 1923,

that I last saw h[illegible] alive on Dec 4, 1923

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. O'Neill M. D.

12/5, 1923 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CAUSE OF BURIAL CONSENT FOR REMOVAL: [illegible] DATE OF BURIAL: Dec 7 23 19

20 UNDERTAKER: Wm Cook ADDRESS: 502 East North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81496

CERTIFICATE OF DEATH.

9 D 81496

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Mc Culloh ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Henry Carson

(a) RESIDENCE NO. 1208 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. V mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/3/23

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
V	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Benj Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country): D. C.

12 MAIDEN NAME OF MOTHER: Ollie Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D. C.

14 Informant (Address): Benj Carson

15 Filed DEC 6 - 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 6, 1923, that I last saw him alive on Dec 5, 1923, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cough Whooping about 3 weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Goodwin M. D.

12/6/23 (Address) 1019 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Laurel Cemetery — DATE OF BURIAL Dec 6-1923

20 UNDERTAKER John H Goodwin — ADDRESS 142 N Hilton

Spec.—1-10-21—M&T—1500 Bks.

D 81497

2047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1769 81497

1-PLACE OF DEATH Hebrew Hosp

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument *ST., 14 WARD)

2-FULL NAME Jeanette Sperling

(a) RESIDENCE NO. 2947 Pennsylvania Ave WARD .....

(Usual place of abode) 2047

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 - 1920

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
2	11	~~27~~ 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER Charles Sperling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Frieda Hirschstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) J. Lewis 1439 E. Baltimore St

15 DEC 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

I HEREBY CERTIFY, That I attended deceased from Dec 5 1923 to Dec 5 1923

that I last saw her alive on Dec 5 1923,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis - Purulent

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pus in abd. cavity

(Signed) Wm Gay Weber, M. D.

19 (Address) 1 W. Mt. Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale Cem.

DATE OF BURIAL: Dec 6 1923

20 UNDERTAKER: Jac Krauss

ADDRESS: 1439 E. Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumococcus
No other history

Spec.—1-10-21—M&T—1500 Bks.

D 81498

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 81498

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 E Fayette ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Keller

(a) RESIDENCE NO. 2325 E Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? 71 yrs. 7 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Andrew

6 DATE OF BIRTH (month, day, and year): Apr 25 52

7 AGE: Years 71 Months 7 Days 9 If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sabilla Jumeau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: George W. Keller

(Address) 2325 E Fayette

DEC 6 - 192[illegible] ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1922, to Dec 4, 1923, that I last saw her alive on 11 11, 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Paralysis

(duration) 1 yrs. 2 mos. 18 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Deaver, M. D.

12-5-1923 (Address) 1701 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: Dec 7 1923

20 UNDERTAKER: Philip Henry ADDRESS: 2016 Aiken

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81499

CERTIFICATE OF DEATH.

3/ D 81499

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2807 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John Schafflein

(a) Residence No... 2807 Elliott St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 1- 1879

7-AGE. 44 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Grocery Co

(c) Name of employer..... Unk

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Schafflein

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Maryland Baltimore

12-MAIDEN NAME OF MOTHER. Margaret Seibert

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Maryland Baltimore

11 (Informant) Dora Schafflein

(Address) 2807 Elliott St.

DEC 6 - 1923 Filed ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 4 1923

17- I HEREBY CERTIFY, That I attended deceased from about May 1 1923 to Dec 4 1923

that I last saw h.. alive on Nov 28 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Not Date of —

Was there an autopsy? Not

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. N. Krug M. D

12/5/ 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem DATE OF BURIAL. Dec. 7, 1923

20-UNDERTAKER. Zickler + Zickler ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 81500

CERTIFICATE OF DEATH.

D 81500

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2240 ST.; Guilford Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel S Corse

(Residence in Baltimore: No. 2240 Guilford Ave St.; 70 yrs., — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH July 1, 1844 (Month) (Day) (Year)

7-AGE, 79 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Frederick Maryland

PARENTS.

10-NAME OF FATHER, Caleb Norris

11-BIRTHPLACE OF FATHER (State or Country). Fredk Co Md

12-MAIDEN NAME OF MOTHER Mary Penn

13-BIRTHPLACE OF MOTHER (State or Country). Fredk Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D Corse

(Address) Corse & Dorcheus

15- Filed DEC 6 - 1923, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1920, to Dec 5 1923, that I saw her alive on Dec 4 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebro Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm D Corse M. D.

Dec 6, 1923 (Address) Corse & Dorcheus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Friends Burial Ground Balto Co Md — DATE OF BURIAL, Dec 7, 1923

20-UNDERTAKER Henry Hoen Son — ADDRESS 1301 E Eager St

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 81501 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81501

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2348 McCulloh ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn K Breckenridge

(a) RESIDENCE. No. 2348 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Edward Breckenridge

6 DATE OF BIRTH (month, day, and year) Jan 31, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Tappahannock
(State or country) Essex Co. Virginia

PARENTS

10 NAME OF FATHER Albert Pitts

11 BIRTHPLACE OF FATHER (city or town) Tappahannock
(State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Ellen Tomlinson

13 BIRTHPLACE OF MOTHER (city or town) Tappahannock
(State or country) Essex Co. Va.

14 Informant John Edward Breckenridge
(Address) 2348 McCulloh St.

15 Filed DEC 6 - 1923 19 ROBERT R. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to Dec 3, 1923, that I last saw h[illegible] alive on Dec 2, 1923 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) / yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William F. Wright, M. D.

Dec. 1923 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Cemetery	12/6 19 23

20 UNDERTAKER Samuel J. Hemsley ADDRESS 1128 Bank

Spec.—1-10-21—M&T—1500 Bks.

Chipman

D 81502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81502

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Chipman

(a) RESIDENCE NO. Mt. Washington, Md. ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? 72 yrs. 9 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Graham Chipman

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1086

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER George Chipman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Jane White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Henry C Chipman

(Address) Mt Washington Md

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1923, to Dec. 4, 1923, that I last saw him alive on Dec. 3, 1923, and that death occurred, on the date stated above, at 5:45 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Chronic valvular heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL STEWART & MOWEN COMPANY WILLIAM F. MOWEN, SUCCESSOR

DATE OF BURIAL 108 W. NORTH AVE 19

20 UNDERTAKER Loudon Park Funeral Dept

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Spilman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81503

CERTIFICATE OF DEATH.

129 D 81503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Windsor Ave WARD 16)

2-FULL NAME Robert Lee Spilman

(a) RESIDENCE No. 3032 Windsor Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Spilman

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Millinery Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ga

PARENTS

10 NAME OF FATHER: Robert Spilman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma Parkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Julia Spilman

(Address) 3032 W Windsor Ave

15 DEC 6 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5" 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Dec 5", 1923, that I last saw him alive on Dec 4th, 1923 and that death occurred, on the date stated above, at 1.30 Am

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. Lepp, M. D.

, 19 (Address) 2048 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Dec 7 1923

20 UNDERTAKER: Martin Fahey & Son — ADDRESS: 1827 N North

Cor.—1-12-23—M&T—100 Bks.

81504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

B 81504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 5 WARD)

2-FULL NAME Moses Chase

(a) RESIDENCE NO 1409 May St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) common
(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge, Md.
(State or country)

PARENTS

10 NAME OF FATHER Moses Chase

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Mary Stanley

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Dorchester Co. Md.

14 Informant StoreS Stanley
(Address) 1927 White Ave.

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock-accidently fell from auto-truck upon which he was riding.-
Rear wheel passed over both legs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Tolen, M. D.
(Coroner)

Dec 6 23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md. DATE OF BURIAL Dec. 6 1923

20 UNDERTAKER Richard F. Cooley ADDRESS 1108 Guilford Ave

Spec.—1-10-21—M&T—1500 Bks.

D 81505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81505

490

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital. ST., 22 WARD)

2-FULL NAME John Stokes

(a) RESIDENCE NO. 403 S. Bond St. ST., 3 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Municipal Hospital Records.

(Address)

DEC 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 26, 1923 to December 1, 1923, that I last saw him alive on December 1, 1923, and that death occurred, on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of April 1922

Was there an autopsy? No

What test confirmed diagnosis? Lab & Operation

(Signed) Claude D. Hinson, M. D.

12-3-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Dec 6 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81506

CERTIFICATE OF DEATH.

49 D 81506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Edmondson Ave. ST., 16 WARD)

2-FULL NAME Adrian Grape

(a) RESIDENCE No. 1024 Edmondson Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catharine Griffin Krell

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wire Chief

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Union Telegraph Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Grape

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Cassard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Elizabeth Grape
(Address) 1024 Edmondson Avenue

DEC 6 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1923, to Dec. 5, 1923, that I last saw him alive on Dec. 5 1923, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of rib

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis in lung (sarcoma)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical - X Ray etc

(Signed) J. Frederick Lentz, M. D.

12-5-23, 19 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/7 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81507

CERTIFICATE OF DEATH.

181-001 D 81507

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1823 (Street) Gough (Ward) 2

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael E. Harrigan

(a) RESIDENCE No. 1823 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Harrigan

6 DATE OF BIRTH (month, day, and year) Oct 30 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dave Harrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Kate Harrigan (Address) 1823 Gough St.

15 Filed DEC 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
Dec 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Dec 7, 1923

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 81508

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 E. Baltimore St St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abramham Cohen

(a) Residence No. 827 Chanucey Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Cohen

6-DATE OF BIRTH (month, day and year) Unkown

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer). U.S.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER David Cohen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unkown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis
(Address) 1439 E Baltimore St

15- Filed DEC 6 1923 19.. Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) ~~Dec 5 192~~

17- I HEREBY CERTIFY, That I attended deceased from March 16 1921 to Dec. 5 1923

that I last saw h.. alive on Dec. 5 1923

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

cerebral Hemmorhage

(Duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stewart Latimer M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Mt Carmel Cem	Dec. 6. 23 19..

20-UNDERTAKER.	ADDRESS
Jack Lewis I439	E Balt St

MARGIN RESERVED FOR BINDING.

D.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81509

CERTIFICATE OF DEATH.

D 81509

175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 402 N. 28th. St. ST., 17 WARD)

2-FULL NAME Rhoda May Grimm

(a) RESIDENCE NO. 402 N. 28th. St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 25-1922

7 AGE — Years: 1 — Months: 7 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael J. Grimm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City. Maryland

12 MAIDEN NAME OF MOTHER: Lida M. Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Maryland

14 Informant (Address): Michael J. Grimm 402 N. 28th. St.

15 Filed , 19 Registrar

DEC 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4 , 1923 , to Dec 5 , 1923 ,

that I last saw h er alive on December 5 , 1923 ,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Poisoning Poison

H. Coroner Jno. H. Mowbray

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Davies , M. D.

12-6 1923 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Dec. 7 1923

20 UNDERTAKER: Horace G. Burgee — ADDRESS: 360 Fallsway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81510

CERTIFICATE OF DEATH.

10 D 81510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 E. Lafayette Ave ST., 16 WARD)

2-FULL NAME George H. Bailey

(a) RESIDENCE NO. 1932 E. Lafayette Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Q. A. Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER George H. Bailey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia L. Smith

13 BIRTHPLACE OF MOTHER (city or town) Q.A. Co
(State or country) Maryland

14 Informant. George H. Bailey
(Address) 1932 E. Lafayette Ave

15 DEC 6 1923 Robert P. [illegible]

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6-1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 30, 1923, to Dec 6, 1923,

that I last saw him alive on Dec 6, 1923,

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure from Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture

(Signed) J. M. Lampmin, M. D.

Dec 6 1923 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec. 7 1923
20 UNDERTAKER Horace A. Burgee	ADDRESS 3631 Hall St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81511

CERTIFICATE OF DEATH.

129

D 81511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21 WARD)

2-FULL NAME Nellie Upperman

(a) RESIDENCE NO. 918 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edgar Upperman

6 DATE OF BIRTH (month, day, and year): Oct 5th 1896.

7 AGE — Years: 27 — Months: 2 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Edgar Upperman

(Address): 918 Burgundy St.

15 Filed DEC 6 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923, to Dec 6, 1923, that I last saw her alive on Dec 6, 1923, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Toxemia

Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

12/6 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Dec 8, 1923.

20 UNDERTAKER: John F. Cowan & Son, per J. F. Cowan

ADDRESS: 901 W. Lafayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81512

CERTIFICATE OF DEATH.

185

D 81512

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

2-FULL NAME Mrs. Sarah A. Barnhart.

(a) RESIDENCE NO. 9 S. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 6 - 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) wife of

6 DATE OF BIRTH (month, day, and year) Unknown 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Allen Atkinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER McGowan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Geo. E. Barnhart
(Address) 1103 W. Fayette St.

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1923, to Dec. 5, 1923, that I last saw her alive on Dec. 5, 1923, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with metastasis to liver

Interval between onset and death (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes - Acute Cardiac dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. T. Hundley, Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec 8 1923
20 UNDERTAKER John F. Cowan & Son Ed. F. Cowan	ADDRESS 901 Holly St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall at home

Spec.—1-10-21—M&T—1500 Blks.

D 81513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81513

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Linden ave ST. 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie [illegible] Brewer

(a) RESIDENCE NO. 1625 Linden ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA... should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): July 1867

7 AGE — Years: 56 Months: 5 Days: If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John W. Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A. VanLear

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Cora Brewer 1625 Linden ave

15 Filed ..., 19... Registrar

Robert P. Harrison, Burial Permit Clerk.

DEC 6 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1923, to Dec 5, 1923, that I last saw h[illegible] alive on Dec 5, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 11 mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Standish McKelvey, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forrane Cemetery — DATE OF BURIAL: Dec 7 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81514

74-09

D 81514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1800 N. Calvert St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Shubert

(a) Residence No. 1800 N Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 15 1883

7-AGE. 40 yrs. mos. 21 ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS

10-NAME OF FATHER Joseph H Shubert

11-BIRTHPLACE OF FATHER (City or town) Balto (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Emma Rud

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Charlotte Wheeler

(Address) 1800 N. Calvert St

15- Filed DEC 6 - 1923 16- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 - 1923 to Dec. 6 - 1923

that I last saw her alive on Dec 6 1923

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

following extensive

congestive pneumonia

of about 5 days duration

*CONTRIBUTORY (Secondary) Chronic nephritis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Objective & subjective

(Signed) [illegible] M. D

19 (Address) 102 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal or Homicidal. (See reverse side for additional space.)

19- PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Dec 8 1923

20-UNDERTAKER, John A Mitchell — ADDRESS 1201 W Fayette

MARGIN RESERVED FOR BINDING.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Bartlett)

D 81515

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 81515

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1744 E Eager ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Bartlett

(a) RESIDENCE NO. 1744 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Bartlett

6 DATE OF BIRTH (month, day, and year) Feb 4 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer Bowlsbey & Shultz

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Bartlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Mackey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Chas. Bartlett

(Address) 1744 E Eager St

15 Filed . 19 Registrar

Robert P. Harrison.

DEC 6 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Dec 4, 1923, that I last saw him alive on Dec 4, 1923 and that death occurred, on the date stated above, at 4-30 p m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms & Physical Signs

(Signed) James D McCamant, M. D.

, 1923 (Address) 416 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Dec. 7 1923

DATE OF BURIAL

20 UNDERTAKER: Wm Cook 502 E 1st Ave.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81516

CERTIFICATE OF DEATH.

D 81516

1-PLACE OF DEATH University Hospital 3

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Romeo

(a) RESIDENCE NO. 1014 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mr Vincent Romeo

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Gerard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Univ. Hosp. Records (Address)

15 Filed DEC 7 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 19 23

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Dec. 5, 1923, that I last saw h[illegible] alive on Dec 5, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Tumor of the Brain

(duration) yrs. 1 mos about ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Nov 16, 1923 (Sub temporal decompression)

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Autopsy findings

(Signed) Hand R. Neuressen, M. D.

Dec 5 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dolan Cemetery — DATE OF BURIAL Dec 8. 1923.

20 UNDERTAKER Randall Dippel & Son — ADDRESS 37 Hanover

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Malignant

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81517

REGISTERED NO. 31 D 81517

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 7 WARD)

2-FULL NAME Cora Easley

(a) RESIDENCE NO. 607 N. Caroline st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Not Given Easley

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H. Kealey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1923, to Dec. 5, 1923, that I last saw h e alive on Dec. 5, 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Lally M. D.

12-5-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easterly Cemetery DATE OF BURIAL Dec 7 1923

20 UNDERTAKER Mrs. R.G. Elliott ADDRESS 1725 Eastlander

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81518

D 81518

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Burns

(a) RESIDENCE NO. 250 S. Spring St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jamie Burns.

6 DATE OF BIRTH (month, day, and year) Mar 6 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Municipal Hospital Records.

15 Filed DEC 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1923, to December 3, 1923, that I last saw him alive on December 3, 1923, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic Aortitis,

Aortic Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude E. Horne, M. D.

12-4-, 1923 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery.

DATE OF BURIAL Dec 7 1923

20 UNDERTAKER Wm. R. G. Elliott

ADDRESS 325 Cathedral

Spec—12-23-21—E.B.R.S.—400 blks.

D 81519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1708 Hollins Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Maria Haskell

(a) Residence No. 1708 Hollins Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles A. Haskell

6-DATE OF BIRTH (month, day and year): January 26, 185[illegible]

7-AGE: 69 yrs. 10 mos. 9 ds. If LESS than 1 day, hrs. or min.:

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Jacob G. Baitzell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth Hartman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant): Miss Bessie M. Haskell

(Address): 1708 Hollins Street

15- Filed DEC 7 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19[illegible], to Dec 5 19[illegible], that I last saw h[illegible] alive on Dec 5-23, and that death occurred, on the date stated above, at 3.24 P m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Chronic Arthritis

(Duration) 15 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) M. G. Smith, M. D.

12-5 1923 (Address) 118 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Dec 8" 19 23

20-UNDERTAKER: Robert B Cook ADDRESS: 1003 N. Paca St

B.—Write carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81520 (Florence Alls)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D 81520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) ST., 8 WARD)

2-FULL NAME Miss Florence Alls

(a) RESIDENCE NO. 1525 Washington Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 27th 1887

7 AGE — Years: 36 — Months: 8 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo. B. Alls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Sarah A. Vineyard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: George B. Alls

(Address): 1525 W. Washington Av

15 DEC 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8 , 1923 , to Dec. 5 , 1923 , that I last saw h[illegible] alive on Dec. 5 , 1923 , and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Secondary anemia - uterine hemorrhage

(duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary): Submucous myoma uteri

(duration) 2 yrs.? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms

(Signed) Harry V. P. Dickson Jr. M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Dec 8 1923

20 UNDERTAKER: Frank A. Fenke

ADDRESS: 910 N. Gay St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81521

CERTIFICATE OF DEATH.

90 D 81521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1711 W. North Ave ST., 15 WARD)

2-FULL NAME Sally Oppenheim

(a) RESIDENCE NO. 1711 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Meyer Oppenheim

6 DATE OF BIRTH (month, day, and year): about 1872

7 AGE: Years: 51 yrs. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Davis Oppenheim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Leopold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Joseph Oppenheim 1711 W. North Ave.

15 Filed DEC 7 - 1923, 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): no history

(duration) yrs. mos. ds.

(Signed) J. E. T. Hennessy M. D. (Coroner)

Dec. 6, 1923 (Address) 208 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Dec 7 1923

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Mad

mrs

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81522

CERTIFICATE OF DEATH.

179 D 81522

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 Eaton Ave, St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret E Holland

(a) Residence No. 704 Eaton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W.

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James F Holland

6-DATE OF BIRTH (month, day and year) Dec 3rd 1844

7-AGE, 79 yrs. — mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Fallston Md

PARENTS

10-NAME OF FATHER, Jacob Minnick.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Elizabeth Coates

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

11- (Informant) Mrs Margt E Holland
(Address) 704 Eaton Ave

13- DEC 7 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5th 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923 to Dec 5, 1923 that I last saw h. alive on Dec 5, 1923 and that death occurred, on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Ulcer on R foot

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) D Winkelpein M. D.

, 19 (Address) 1803 W Lorraine

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 8, 1923
20-UNDERTAKER.	ADDRESS
Peter Gilmore	1123 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec. 1-10-21-MAT-1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81523

CERTIFICATE OF DEATH.

3 | D 81523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Adams (Baker)

(a) RESIDENCE NO. 604 Orange Court ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Perry Adams

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 621

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Stephen Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1923, to Dec. 4, 1923, that I last saw her alive on Dec. 4, 1923, and that death occurred, on the date stated above, at 11.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum X-ray

(Signed) L. A. Lally, M. D.

12-4-23 (Address) Municipal Tuberculosis Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M.T. Auburn

DATE OF BURIAL 12/7 1923

20 UNDERTAKER James F. Lennis

ADDRESS 1203 Eastern

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81524

CERTIFICATE OF DEATH.

31 D 81524

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Sybara

(Residence in Baltimore: No. 834 N. Chapel St.; 22 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 17, 1887
(Month) (Day) (Year)

7-AGE. 36 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Sybara

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Marie Vit

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph W. Sybara

(Address) 834 N. Chapel St.

15- Filed DEC 7 - 1923, 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 8 1923, to December 2 1923, that I saw h[illegible] alive on December 2 1923; and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

a. Laryngeal Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

(Signed) Anselm L. Linck M. D.

December 6 1923 (Address) 1717 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 8, 1923

20-UNDERTAKER Paul Bracken — ADDRESS 1906 Eastlan[illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81525

CERTIFICATE OF DEATH.

161-D 81525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Gen Hosp. WARD 22)

2-FULL NAME Baby Ahlan (Cohlan)

(a) RESIDENCE NO. 419 So Hanover st. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1923

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

X lived about 3 minutes

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred J. Ahlan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass.

12 MAIDEN NAME OF MOTHER Fannie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14

Informant

(Address)

Filed NOV 27 1923

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923, 2.30 p m. to Nov 17, 1923, 2.05 p m.

that I last saw him alive on Nov 17, 2:05 p m. 1923

and that death occurred, on the date stated above, at 2:05 p m.

The CAUSE OF DEATH* was as follows:

Premature delivery

Spontaneous abortion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thurston Common, M. D.

19 (Address) 4724 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laboratory South Balto Gen Hospital

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81526

CERTIFICATE OF DEATH.

137 D 81526

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 18

2-FULL NAME Mariam Bell Glass

(a) RESIDENCE No. 1225 Lombard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 7 mos. 7 ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel H. Munday

11 BIRTHPLACE OF FATHER (city or town) Burnley
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mabel B. Glass

13 BIRTHPLACE OF MOTHER (city or town) Burnleys
(State or country) Virginia

14 Informant Foster mother
(Address) 1225 Lombard Street

15 Filed DEC 7 - 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923, to Dec. 6, 1923, that I last saw h alive on Dec. 6, 1923, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & symptoms

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER John J. Gribbs

ADDRESS 1200 N. Lombard

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81527

HEALTH DEPARTMENT—CITY OF BALTIMORE

440 81527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Hughes

(a) Residence No. 915 Lemon St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1863 July 30

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Ofc

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Edward Hughes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Municipal Hospital Records

(Address).....

15- Filed DEC 7 - 1923 by ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1923 to December 5 1923

that I last saw h. im alive on December 5 1923

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Carcinoma

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Lung

(Duration) 2 yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of June '23.

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Fulton M. D

12-6-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Peters	Dec 8, 1923

20-UNDERTAKER. John DeSelds ADDRESS 1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81528 — 111-00 — D 81528

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S.M.H. Hospital #1. ST., 1V WARD)

2-FULL NAME James Steward.

(a) RESIDENCE No. U.S. Marine Hospital No 1. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Steward.

(c) Name of employer Owner Stanley.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James L. Stewart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Va Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Nain
(Address) 2042 Gough st

15 Filed DEC 7 - 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1923, to December 4 1923, that I last saw h[illegible] alive on Dec 4, 1923 and that death occurred, on the date stated above, at 7 10 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Dilatation, following Gastro-Enterostomy for Duodenal Stenosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Duodenal Stenosis.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Va Beyond

Did an operation precede death? Yes Date of 11/28/23

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) M. H. Foltz. M. D.

Dec. 19 (Address) Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 7 1923

20 UNDERTAKER Robt Turner Sons — ADDRESS 1412 N. Brady 1440 N. Broadway.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Duodenal Ulcer

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81529 ✓ D 81529

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S Robinson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Battee

(a) RESIDENCE NO. 125 S Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24 1920

7 AGE: Years 3 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Robt R. Battee

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Kline

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Robt R. Battee

(Address) 125 S. Robinson st

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 5 1923, that I last saw him alive on Dec 5, 1923, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? no ——

What test confirmed diagnosis? none

(Signed) Allen C. Feetham, M. D.

12-7 1923 (Address) 3139 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Dec 8 1923

20 UNDERTAKER: Robt J Turner & Son — ADDRESS: 1842 E Broadway

Spec.—1-10-21—M&T—1500 Bks.

Burial 1100 W Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81530

CERTIFICATE OF DEATH.

3/ D 81530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 718 Norfolk Ave ST.) Fulton Park WARD 15

2-FULL NAME Mark Aloysius Grimes

(a) RESIDENCE NO. 718 Norfolk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61/2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rice's Bakery

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edwd. Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine McCaffrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward A. Grimes (Address) 718 Norfolk Ave

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1923, to Dec 6th, 1923,

that I last saw h[illegible] alive on Dec 5th, 1923

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs - He has been an inmate at the Md. State Sanatorium, Sent home the last week. He has been sick for a yr. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? None Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Chas. H. Bryant M. D.

Dec 6th, 1923 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 10 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Hoffman

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81531

CERTIFICATE OF DEATH.

188-003 D 81531

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) 6 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dudley

(a) RESIDENCE NO ~~Annapolis Md.~~ 316 N. Ann St (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 Yrs mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
17	97			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknmnown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Philip S. Dudley
(Address) 421 N. High St

15 Filed DEC 7 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen'l Shock-senility, following amputation of right foot, ~~8 days~~ died 8 days after operation.

(Autopsy at (duration present) mos ds.

CONTRIBUTORY (Secondary) automobile accident

(Inquest to be held Dec 6/23 mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Dec 6 23 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 12 7 192 3

20 UNDERTAKER David Easter

ADDRESS 916 Gay ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81532

100-08 B 81532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 Bruce St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. F. Butler

(a) Residence No. 215 Bruce St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, mal

4-COLOR OR RACE, col

5-Single, Married, Widowed, or Divorced, — (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 17-71

7-AGE, 7 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... HW

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country).....

PARENTS.

10-NAME OF FATHER, Mrs. F. Butler

11-BIRTHPLACE OF FATHER (city or town)..... Balto.
(State or Country).....

12-MAIDEN NAME OF MOTHER, Ella Penny

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country).....

14-

(Informant) David Easter

(Address)..... 916 Bruce

15-

Filed..... 192.....

OCT 7 - 1923 ROBERT R. KRAUTZ, Registrar.

MEDICAL CERTIFICATE OF DEATH. 1923

16-DATE OF DEATH (month, day and year). Dec. 6

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec 5, 1923

that I last saw him alive on Dec 5, 1923

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

.....(Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

.....(Duration).....yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frank Hinkelmann M. D.

12/6, 1923 (Address) 1016 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet | DATE OF BURIAL, 12-8-23

20-UNDERTAKER David Easter | ADDRESS 916 Bruce

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81533

CERTIFICATE OF DEATH.

31 D 81533

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 27 WARD)

2-FULL NAME Edna Lucas

(a) RESIDENCE NO. 711 Glenwood ave. Govans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893 Nov 17

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John T. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Totsauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records (Address) M.T.H.

15 DEC 7 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec. 5, 1923.

that I last saw her alive on Dec. 5, 1923,

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 ? yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis caused by Brain Cyst (Benign) (duration) 2 yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan. 1921

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

12-6-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Dec 8 1923

20 UNDERTAKER Jos Joerdens Son ADDRESS 2178 Pa. Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

761-001

D 81534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D 81534

CITY OF BALTIMORE: (No. 1517 W. Lexington ST., 19 WARD)

2-FULL NAME Baby McCall

(a) RESIDENCE No. 1517 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1923

7 AGE ✓ Years ..... Months ..... Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none old

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ralph Matthews

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country) Md.

12 MAIDEN NAME OF MOTHER Berenice McCall

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mother
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.
0541

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 4, 1923,
that I last saw her alive on Dec 3, 1923
and that death occurred, on the date stated above, at 11 AM m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas Lee, M. D.

12/4, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL .....

20 UNDERTAKER Commissioner of Health.
per. Wm. E. WOODALL

ADDRESS DEC 6 - 1923

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17484 D 81535 — 161-006 D 81535

REGISTERED NO. .....

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Leverton

(a) RESIDENCE No. 1645 E. Eager St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 27/1923

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
—	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Leverton

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Anna Strickler

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) Johns Hopkins Hospital

15 DEC 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Dec 5, 1923.

that I last saw her alive on Dec 5, 1923,

and that death occurred, on the date stated above, at 6-20 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life yrs. mos ds.

CONTRIBUTORY (Secondary) Abscess of neck

(duration) 0 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) H. N. Wood, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL Dec 7 1923

20 UNDERTAKER Philip Henrig ADDRESS 2016 Orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MA T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81536

D 81536

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Carson

(a) RESIDENCE NO. ..... Old Fort, N. C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years: 37 | Months: ? | Days: ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Railroad

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Martha Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 1 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 5, 1923, that I last saw him alive on Dec 5, 1923, and that death occurred, on the date stated above, at 6 25 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor. Glioma Malignant

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? Yes Date of 12-5-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M. Firor, M. D.

12/6 1923 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Marion N. C.

DATE OF BURIAL: 12/7 1923

20 UNDERTAKER: Samuel Stanley

ADDRESS: Marion N. C.

D 81537

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81537

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 N. Mount St. 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George M. Paris

(Residence in Baltimore: No. 908 N. Mount St. St.; yrs. 7 mos. 15 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

(a)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the Word.): Single

6-DATE OF BIRTH: April 22 (Month) (Day) 1923 (Year)

7-AGE: yrs. 7 mos. 15 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer): (Infant)

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER. Edward A. Paris

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Martha E. Bradley

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward A. Paris

(Address) 908 N. Mount St.

15- Filed DEC 7 1923 19.. Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 7 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

second degree burns of right arm, side & leg

(Duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Dec. 7, 1923 (Address) 2812 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. Dec 7 19..

20-UNDERTAKER. H. Mc Cole ADDRESS 502 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81538

CERTIFICATE OF DEATH.

D 81538

REGISTERED NO. 1601

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Maryland Ave ST., 6 WARD)

2-FULL NAME Anna Schulz

(a) RESIDENCE NO. 1511 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-23

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John L. Cuty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barnadetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed DEC 7 1923, 19 Registrar

Robert P. Garrison, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1923, to Dec 6, 1923.

that I last saw h alive on Dec 6, 1923,

and that death occurred, on the date stated above, at 1200 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

of the Male Genitalia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Dec 7, 1923 (Address) 320 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Dec 7 1923

20 UNDERTAKER Chas C. Miller ADDRESS 2334 Jeffer

Spec.—1-10-21—M&T—1500 Blks.

D 81539

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 81539

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3001 Cedar Ave. ST., 13 (WARD)

2-FULL NAME Sadie E. Shuler

(a) RESIDENCE NO. 3001 Cedar Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 18-1923

7 AGE — Years: — Months: 8 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm. E. Shuler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Sadie M. Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Wm. E. Shuler 3001 Cedar Ave

15 Filed Dec. 8 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1923 to Dec 6 1923, that I last saw he alive on Dec 6 1923, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Richardson, M. D.

Dec. 8 1923 (Address) 112 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Marys (Hampden) — DATE OF BURIAL: Dec. 8 1923

20 UNDERTAKER: Horace M. Burgee — ADDRESS: 3134 Falls Rd.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EC 7-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81540

D 81540

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 W. Lanvale St., 11 WARD)

2-FULL NAME Elizabeth Welsh Knox

(a) RESIDENCE NO. 225 W. Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of The Late John S. Knox

6 DATE OF BIRTH (month, day, and year) April 1, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warrenton Va.

PARENTS

10 NAME OF FATHER Joseph Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warrenton Va.

12 MAIDEN NAME OF MOTHER Eliza Baylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clarke Co. Va.

14 Informant William R. Robins

(Address) 225 W. Lanvale St.

15 Filed DEC 7 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 7. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Dec 7th, 1923, that I last saw him alive on Dec 6th, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Fr. Hip - old age

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. Lobstein M. D.

12-7-1923 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria Va DATE OF BURIAL Dec 9 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81541 — 4446 81541

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5112 (St.) Harford Road (WARD) 21

2-FULL NAME Rosa Sales

(a) RESIDENCE NO. 5112 (Usual place of abode) Harford Road WARD .....
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm K. Sales

6 DATE OF BIRTH (month, day, and year): Jan 7 1867

7 AGE: Years 54 | Months 10 | Days 21 | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael Shandel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Klug

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm K. Sales
(Address) 5112 Harford Rd

15 Dec 8 1923 Robert F. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923 to Dec 8, 1923
that I last saw h[illegible] alive on Dec 8, 1923
and that death occurred, on the date stated above, at 8.50 m.
The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cancer of Uterus

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. Hayward Sumner M. D.
1923 (Address) 5 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery | DATE OF BURIAL: Dec 8 1923

20 UNDERTAKER: F. A. Krause & Son | ADDRESS: 705 Hamburg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

DEC 8 1923

Cor.—1-12-23—M&T—100 Bks.

(Alexander Schwappe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81542

D 81542

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) 917 Morris alley ST., 16 WARD)

2-FULL NAME Alexander Swoapps. (Schwappe)

(a) RESIDENCE NO. 917 Morris alley ST.; ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 20 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Swoapps. Schwappe

6 DATE OF BIRTH (month, day, and year) about 1873 (guess)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
50 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (Schwappe)

14 Informant Mamie Swoapps (Schwappe)
(Address) 917 Morris alley.

15 Filed DEC 8-1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. & T. Hennessy, M. D.
(Coroner.)

Dec. 7, 1923 (Address) 28 Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel, Cemetery	Dec 8 192
20 UNDERTAKER Mrs Robert H Elliott	ADDRESS 1125 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81543

CERTIFICATE OF DEATH.

74-001 D 81543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Stirling ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Babetta Guilta

(a) RESIDENCE No. 1018 Stirling ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of the late John Guilta
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework ad

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Kn

14 Informant Mr. John. M. Guilta

(Address) 1018 Stirling St

15 Filed DEC 8 - 1923, 19

Robert F. HARRISON,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1923, 19 to Dec 7 1923, 19 that I last saw h alive on Dec 7 1923, 19 and that death occurred, on the date stated above, at 7.25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) Unk yrs. mos 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Lowe M. D.

Dec 7, 19 23 (Address) 501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 10 1923
20 UNDERTAKER	**ADDRESS**
Henry Hoeck Son	130 E Eager St

Cor.—1-12-23—M&T—100 Bks.

D 81544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D 81544

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

2-FULL NAME Enda Jones

(a) RESIDENCE NO. 508 Penna ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Alex Day

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Milly Jones

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Estell Davy
(Address) 502 N Bruckelyd

15 Filed ..... 192 .....

Registrar

DEC 6 - 1923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) struck with a club by Moly Jones

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H R Gonichy, M. D.
(Coroner.)

12-7 .192 3 (Address) 717 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northumberland Va DATE OF BURIAL Dec 8 1923

20 UNDERTAKER R B Scott ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81545

HEALTH DEPARTMENT—CITY OF BALTIMORE

33

D 81545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 N. mount ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Louis Wise

(a) RESIDENCE NO. 409 N. mount ST., WARD

(Usual place of abode) whole life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should prepare CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 11 - 1907

7 AGE: 16 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: school boy

(b) General nature of industry, business, or establishment in which employed (or employer): High school

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Sam. L. Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Effie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Orangie Wise

(Address): 409 N. mount St.

15 Filed DEC 8 1923, 19

Robert F. Garrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 6 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1923, to Dec. 6 - , 1923,

that I last saw him alive on Dec. 6 - , 1923,

and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

Chronic

(duration) — yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Chas. L. Ons Carter, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: Dec 10 1923

20 UNDERTAKER: R. L. Goss

ADDRESS: 1405 McElderry

Cor. 1-13-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81546

CERTIFICATE OF DEATH.

90 D 81546

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Found Dead on corner N. Wash & Collington Ave (WARD)

2-FULL NAME Frank Tuttle

(a) RESIDENCE NO 115 S. Register ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Tuttle

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chili

PARENTS

10 NAME OF FATHER John Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chili

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chili

14 Informant Anna Tuttle
(Address) 115 S. Regester St.

15 Filed ..... 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

DEC 8-1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(Probably)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

(Signed) J. S. H. Wallace, M. D.
(Coroner.)

Dec 8/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 12/10 1923

20 UNDERTAKER Lilly Beiler 403 S. Wolfe ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81547

CERTIFICATE OF DEATH.

100-001 B 81547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

2-FULL NAME John Holtzman

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1923 to December 6, 1923, that I last saw him alive on December 5, 1923, and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Job

(Signed) C Claude F. Hancock, M. D.

12-7-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem,

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

DEC 8 - 1923

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81548

D 81548

113

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2d Ave + 19th St., 76 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME George E. Haas.

(a) Residence No. 2d ave + 19th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 15 1923

7-AGE. yrs. 3 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER, George Haas. Jr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER, Katharine E. Alvater

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto., Md

14- (Informant) George Haas Jr.

(Address) 2d Ave + 19th St.

15- Filed DEC 8 1923 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 8 1923.

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 5 1923 to Dec 8 1923

that I last saw h~~i~~m alive on Dec 7 1923

and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Alcoholism Acute

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Fitlow M. D

12/8/ 1923 (Address) 315 S. Highland Ave

* State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19..
Mt. Carmel	Dec 8 23
20-UNDERTAKER.	ADDRESS
Burkler Burkler	1759 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81549

CERTIFICATE OF DEATH.

117 D 81549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Balto Gen Hosp ST., 27 WARD)

2-FULL NAME Mrs. Grace M. Ely

(a) RESIDENCE NO. 702 Spring Hill Terrace, Govans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Ely

6 DATE OF BIRTH (month, day, and year) Dec 31 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Cyrus R Heller

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Mamie Matthews

13 BIRTHPLACE OF MOTHER (city or town) W Va (State or country)

14 Informant Hattie Weaver (Address) 702 Spring Hill Ter

15 Filed ..., 19.. Robert J. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 6.30 p.m., 1923, to Dec 5 5.35 1923, that I last saw her alive on Dec 5, 1923 and that death occurred, on the date stated above, at 5.35 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Cardiac dilatation.

Nephritis.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute appendicitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of December 4/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Young, M. D.

, 19 (Address) 4704 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER H J Thomas Sons

ADDRESS Walk 16

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81550

CERTIFICATE OF DEATH.

164 D 81550

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 N. Lexington St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Dapp.

(a) RESIDENCE. NO. 1736 N. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie C Dapp

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 86 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Virginia C Fidler
(Address) 736 N Lexington

15 Filed DEC 8 1923 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1923, to Dec 6, 1923, that I last saw h[im] alive on Dec 6, 1923, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray M. D.

Dec 7 1923 (Address) 510 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Dec 10 1923

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Fayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can he known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will he sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

None

D 81551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 81551

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 W Lombard St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luke McTigue

(Residence in Baltimore: No. 936 W Lombard St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. Unknown (Month) (Day) 1848 (Year)

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Star Mason
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Eugene McTigue

(Address) Cumberland, Md.

15- Filed DEC 8 1923 192 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 7th (Month) (Day) 192 3

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) yrs. mos. ds.

(Signed) Geo E Blades M. D.
(Coroner)

Dec 8-23 192 (Address) 142 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem. DATE OF BURIAL. Dec 10 1923

20-UNDERTAKER: John J Gowan & Son ADDRESS 901 Park Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERIL, WITH CAPABILITY IN—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81552 D 81552

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital, ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hennie Herzberg

(a) RESIDENCE NO. Esplanade Aprt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be carefully answered. If information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24th. 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip Herzberg,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Bertha Thanhouser,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. H. Witz, (Address) Esplenade Aprt.

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6. 1922, to Dec 7. 1923.

that I last saw her alive on Dec 6. 1923

and that death occurred, on the date stated above, at 4 25 A m

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (left)

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Carcinomatosis (metastasis) pulmonary (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of Sept 11 1922

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Radiographic

(Signed) Louis P. Haenburger, M. D.

Dec 7. 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION ~~OR REMOVAL~~ Loudon Park, DATE OF BURIAL Dec. 10th 23

20 UNDERTAKER David Sondheim ADDRESS 18 W Lexington

Spec.—1-10-21 M&T 1500 Bks.

D 81553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 D 81553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marjeane Aprt. A-1. ST., 13 WARD)

2-FULL NAME Augusta Mothner,

(a) RESIDENCE NO. Marjeane Aprt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Mothner,

6 DATE OF BIRTH (month, day, and year) April 29th. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany,

PARENTS

10 NAME OF FATHER Himan Jacobs,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) germany,

14 Informant Mrs. J. Epstein,

(Address) Marjeane Aprt.

15 Filed DEC 8-1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th. 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 1923, to 12-6-, 1923, that I last saw her alive on 12-6, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Haemoplegia (apoplexy)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis one side of body

(Signed) Harry Feldberg M. D.

12/7 1923 Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. DATE OF BURIAL Dec. 9th 1923

20 UNDERTAKER Harry Sondheim ADDRESS 118 N. Mt. Royal Ave

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81554

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 647 No Kenwood Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Susan

(a) Residence No..... 647 No Kenwood Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6-DATE OF BIRTH (month, day and year): Dec 1-23

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry Susan

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Della Mavronicles

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country),

14-

(Informant)..... Mother

(Address).....

15-

Filed ..... 192 .....

Registrar.

DEC 8-1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 1-23

17- I HEREBY CERTIFY, That I attended deceased from Dec 1- ....., 1923., to Dec 1 ....., 1923, that I last saw h alive on... Dec 1 ....., 19.23, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Faulty - (Transverse presentation) Slight Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malformation - Contracted Palate

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Ruth L. Valentine M. D.

Dec 1, 1923 (Address) 14 So Bowse

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Patrick Cemetery — DATE OF BURIAL, Dec 8, 1923

20-UNDERTAKER, Leo M Fenton Son — ADDRESS 811 N Wolfe St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81555

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Brune ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Anderson

(a) RESIDENCE NO. 504 Brune St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/5/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None MD

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER WM. CARTER

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mother (Address)

15 Filed DEC 8 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 5, 1923, that I last saw her alive on Dec 5, 1923 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adolph Rech, M. D.

12/7, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 8 1923

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 8 1923

Spec.—1-10-21—M&T—1500 Bks.

D 81556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81556

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 28th Ward)

2-FULL NAME Geo J. Akers

(a) RESIDENCE NO. Mt Hope Retreat St. 28th Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 10, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Cornelius Akers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md -

12 MAIDEN NAME OF MOTHER Ella Hanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Records of Mt Hope Retreat
(Address) Baltimore Md -

15 Filed ..... 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9th, 1923, to Dec 6th, 1923, that I last saw him alive on Dec 5, 1923, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - (Pulmonary)

abt 3 or 4 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Depr - Psychosis

abt (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Flannery M. D.

Dec 6th, 1923 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/10 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 8 - 1923

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81557

CERTIFICATE OF DEATH.

X 58-60

D 81557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1011 Woodbourne ST., (WARD) 27

2-FULL NAME Helen G. B. Dauchy

(a) RESIDENCE NO. 1011 Woodbourn ST., WARD Mount Kisco N. Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander J. Dauchy

6 DATE OF BIRTH (month, day, and year) May 20-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	66	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn N. Y.

PARENTS

10 NAME OF FATHER B. B. S. Barnhard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Helen Starr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Wm. H. Barnard. (Address) 1011 Woodbourn

15 Dec 8 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Dec 8, 1923, that I last saw her alive on Dec 7, 1923, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General decline

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Dec 8, 1923 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rural bur Poughkeepsie N.Y. DATE OF BURIAL 12/10 1923

20 UNDERTAKER J. Frew McConnell ADDRESS 130 E. Fort

DEC 8-1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

† 74-001 D 81558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3525 Greenmount Ave ST., 9 WARD)

2-FULL NAME Elizabeth Mintdrop—

(a) RESIDENCE NO. 3526 Greenmount ave WARD Cumberland Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~Divorced~~, (write the word)
Female	White	Widowed

5a ~~If married~~, widowed, ~~divorced~~

~~If married~~) WIFE of John Mintdrop

6 DATE OF BIRTH (month, day, and year) Dec 3. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frances Paulus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schmoor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary L. Bains

(Address) 3525 Greenmount Ave

15 DEC 8 - 1923 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Dec 7, 1923, that I last saw h alive on Dec 6, 1923 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Cumberland. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward J. Feeley, M. D.

, 19 (Address) 3523 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	12/10/23
20 UNDERTAKER	ADDRESS
H. E. Hughes, 424 N. Broadway.	

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81559

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1342 North Eden St. ST., 9 WARD)

2-FULL NAME Mary Elizabeth Hooper.

(a) RESIDENCE NO. 1342 North Eden St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widowed

5a ~~Unmarried~~, widowed, ~~or Divorced~~
(or) WIFE of James R. Hooper.

6 DATE OF BIRTH (month, day, and year) June 1st 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Thomas Spencer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosann Butler

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Nellie Hooper
(Address) 1342 North Eden St.

15 Filed DEC 8 1923, 19 ..... Registrar
Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 1922, to Dec. 6 1923.

that I last saw her alive on Dec. 6 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis, No hemorrhage

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

12/7/1923 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12/10/23 19
20 UNDERTAKER	ADDRESS
H. E. Hughes.	424 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 81560 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81560

CERTIFICATE OF DEATH. 138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (ST.) 17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Randolph

(a) RESIDENCE No. 596 W. Lanvale (ST.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 28-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Townsend Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Thompson Aunt

(Address) 1622 Decatur St N.W. Wash. D.C.

15 Filed: DEC 8-1923 . 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-7 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-4 . 1923 . to 12-7 . 1923 .

that I last saw her alive on 12-7 . 1923 .

and that death occurred, on the date stated above, at 12:15 P.M. in.

The CAUSE OF DEATH* was as follows:

Acute Suppurative appendicitis

(duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY (Secondary): General Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-5th & 6th-23

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Thornwood Wilson M.D.

. 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Purcellville, Va.

DATE OF BURIAL: Dec. 9th 1923

20 UNDERTAKER: Jno W. Downey

ADDRESS: 309 Druid Hill

Spec. 1-10-21 M&T 1500 Blks.

D 81561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81561

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 Park Ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Wilmer Venable

(a) RESIDENCE NO. 1531 Park Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30th 1852

7 AGE: Years 70; Months; Days; If LESS than 1 day, ... hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER J. P. B. Wilmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Helen Shipwith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Edward Venable (Address) 1531 Park Ave

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

DEC 8-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25th, 1923, to Dec 7th, 1923,

that I last saw h[illegible] alive on Dec 7th, 1923,

and that death occurred, on the date stated above, at 1-A m.

The CAUSE OF DEATH* was as follows: Acute dilatation ~~Failure of compensation~~ due to Cardiac Hypertrophy (Chronic Myocarditis)

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis - Hemiplegia

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Van Ness, M. D.

12/8, 1923 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Virginia — DATE OF BURIAL: Dec 9th 1923

20 UNDERTAKER: Henry W. Jenkins Sons Co — ADDRESS: Richard & Battle Sts

Spec. 1-10-21—M&T—1500 Bks. 81562

D 81562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81562 ✓ OK H.H. Gosnell Coroner M.D.

CERTIFICATE OF DEATH.

T 129

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E. Perry

(a) RESIDENCE NO. 120 Broad St. Norwich, Conn. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt. 55 or 60.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) traveling salesman

(c) Name of employer Farrington & Richardson Arms Co.

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Wm. E. Perry

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) U.S.

12 MAIDEN NAME OF MOTHER Harriet Pease

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records

(Address) Mrs. Ida Perry, 9 Mt. Morris Pk. W.

15 DEC 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 7, 1923, to Dec 7, 1923, that I last saw h alive on Dec 7, 1923, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Diffuse Nephritis

Ch. Arteriae Hypertension.

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Blood Chemistry- Blood Pressure Urinalysis

(Signed) Geo. E. Wells, M. D.

, 19 (Address) 1521 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York	Dec 9. 1923

20 UNDERTAKER Harry Hollitz Co. ADDRESS 153 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Bott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81563

D 81563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bott

(a) RESIDENCE NO. Westminster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8 1848

7 AGE: Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lizzie Heathcote

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Martin L. Bott

(Address) Westminster Md.

15 Filed DEC 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1923, to December 8 1923, that I last saw her alive on December 8 1923 and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 33 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 11/25/23

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) James H Bleeker, M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster — DATE OF BURIAL 12/4 19 23

20 UNDERTAKER: H Bankard & Son — ADDRESS Westminster Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81564

CERTIFICATE OF DEATH.

#D 81564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2941 Westwood Ave

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME William H. H Singleton

(a) RESIDENCE No. 2941 Westwood Ave ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Ann Singleton

6 DATE OF BIRTH (month, day, and year) Mar 22. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lt Officer Parks

(b) General nature of industry, business, or establishment in which employed (or employer) Park Officer

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER William H H Singleton

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E Kimsted

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Mary E Hutson
(Address) 2941 Westwood Ave

Filed DEC 9 - 1923 ROBERT R. KRAUTZ Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to Dec 8th, 1923, that I last saw h alive on Dec 7th, 1923 and that death occurred, on the date stated above, at 1.10 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(duration) yrs. 5 mos 20 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Physical findings

(Signed) Herbert R. Spahr, M. D.

Dec 8, 1923 (Address) 2048 N. Monto Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 11 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 81565

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkinns Hospital ST., 2 WARD)

2-FULL NAME Israel Krive

(a) RESIDENCE NO. 2038 E Fayette St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 23 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Krive

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Presser 680
(b) General nature of industry, business, or establishment in which employed (or employer) Mens Clothing
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Krive

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) I439 E Baltimore St

15 DEC 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- operation for rupture of intestine- sigmoid.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) volvulus-several yrs ago

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Fuller, M. D.
(Coroner)

Dec 9 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem 12 — DATE OF BURIAL 9 — 23 1923

20 UNDERTAKER Jack Lewis I439 E Balto St ADDRESS

INSTRUCTIONS—WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81566

188-093 ✓

D 81566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Towson

(a) RESIDENCE No 19 Dodson Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Towson

6 DATE OF BIRTH (month, day, and year) March 4/1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Butter & eggs

(c) Name of employer C.Poehlman & Sons

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George W.Dodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Annie M. Frisby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Md.

14 Informant Grace Walker (sister)

(Address) 310 N. Stricken ST.

15 DEC 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thoracic Hemorrhage- Automobile Accident

(Inquest to be held Dec 10/23)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S H Collins, M. D.

(Coroner)

Dec8/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/10 192
20 UNDERTAKER	ADDRESS
Jas H Goodwin	142 W Hill St

Burial Permit to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stanislaus G. Wroblewski

Spec.—1-10-21—M&T—1500 Bks.

D 81567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81567

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Morrison ST., 25 WARD)

2-FULL NAME St. Frank Wroblewski

(a) RESIDENCE NO. 1406 Morrison ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Wroblewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Valeryo Sydlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Wroblewski (Address) Curtis Bay

ROBERT H. KNAUER

15 Filed DEC 9 - 1923 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to Dec 8, 1923, that I last saw him alive on Dec 8, 1923 and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon L Bosca M. D.

Dec 8, 1923 (Address) Curtis Bay Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. AHC — DATE OF BURIAL 12/10 1923

20 UNDERTAKER William Fialkowski 1614 — ADDRESS Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81568

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

D 81568

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Dolores Dunleavy

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD New Rochelle NY.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 53 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	53	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City -

PARENTS

10 NAME OF FATHER Michael Dunleavy

11 BIRTHPLACE OF FATHER (city or town) New York City (State or country) Annie Drowsey, New York

12 MAIDEN NAME OF MOTHER Annie Drowsey

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md -

15 Filed DEC 9 - 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1923, to Dec 7, 1923, that I last saw her alive on Dec 7, 1923, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Gastric Ulcer -

abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr Depressed Psychosis abt (duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New York City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Rochelle - NY. DATE OF BURIAL Dec 9 1923

20 UNDERTAKER CHARLES F. BROWN COMPANY (CHARLES F. BROWN, Graduate) ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81569

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Park Av ST., 11 WARD)

2-FULL NAME Catherine Nevitt Steele

(a) RESIDENCE NO. 1315 Park Av ST., 11 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? 13 yrs. 10 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) January-19-1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or... min.
	13	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Hampton Steele

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine P. Toney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hampton Steele (Father)
(Address) 1315 Park Ave.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
DEC 9 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 7th 1923.

17 I HEREBY CERTIFY, That I attended deceased from October, 1922, to Dec. 7th, 1923.

that I last saw her alive on Dec. 7th, 1923.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis —

(duration) — yrs. 15 mos — ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No — Findings —

What test confirmed diagnosis? Clinical & Physical

(Signed) Chas. Candler M. D.

Dec 8, 1923 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Dec-10-1923

20 UNDERTAKER STEWART & MOWEN COMPANY, WILLIAM F. WOODEN, Successor — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
AGE should be carefully supplied. AGE should be stated EXACTLY. PHY
mation should be carefully supplied. AGE should be stated EXACTLY. Exact st
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact st
TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81570

CERTIFICATE OF DEATH.

1893-002

D 81570

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Shelley

(Residence in Baltimore: No. Levering House St.; yrs., 53 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH.

..... 1870
(Month) (Day) (Year)

7-AGE. About 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): City

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William Shelley

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Hogan

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Flack

(Address) 1007 W. Lombard St.

15- DEC 9 - 1893 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6, 1893
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

12-7 1893 (Address) 149 N. Broadway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State 53 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. Levering House

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Dec 10 1893

20-UNDERTAKER.	ADDRESS
Jos B Cook	1003 W Balto.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81571

CERTIFICATE OF DEATH.

11-00 D 81571

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 N. Monroe ST., 20 WARD)

2-FULL NAME Laura B. Huster

(a) RESIDENCE No. 110 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Chas Huster

6 DATE OF BIRTH (month, day, and year): April 1844

7 AGE: Years 79 Months 8 Days 6 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W Va

PARENTS

10 NAME OF FATHER: Peter Zinn

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Jane Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant: Mrs Valentine

(Address): 1209 W Franklin St

15 Filed DEC 9 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 6, 1923,

that I last saw her alive on Dec 6, 1923,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

12/8, 1923 (Address) 105 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 12/10/23

~~20~~ UNDERTAKER: Jno A. Farley Sucsr

ADDRESS: 4 Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81572

CERTIFICATE OF DEATH.

× 78 D 81572

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arleen Frick

(a) RESIDENCE NO. Wellsville N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	11 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wellsville Ny.

PARENTS

10 NAME OF FATHER George D Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Catherine Watrous

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 9 - 1923 ROBERT R. KRAUTER, Registrar of Burial Permits.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1923, to Dec 8, 1923, that I last saw h(er) alive on Dec 8, 1923, and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Jacksonian Epilepsy - (post traumatic - birth)

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebrospinal meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 26 1920 Nov 28 1923

Was there an autopsy? Yes partial

What test confirmed diagnosis? Operation

(Signed) T. E. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wellsville N. Y.

DATE OF BURIAL 12/9 1923

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1180 W. Royalave

Spec.—1-10-21—M&T—1500 Blks.

Dietrich

D 81573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 81573

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dietrich

(a) RESIDENCE NO. Mt Hop. Retreat ST., 28 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Dietrich

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe factory - 08

(b) General nature of industry, business, or establishment in which employed (or employer) Making Shoes

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos. Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Germany

12 MAIDEN NAME OF MOTHER Barbara Slatter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Germany

14 Informant (Address) Records of Mt Hope Retreat Mt Hope

15 Filed DEC 9 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9 1891 to Dec 8th 1923, that I last saw her alive on Dec 7th 1923, and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Accidental)

abt 10 minutes (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Dispr. Tricuspid

abt (duration) 32 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Flannery, M. D.

Dec 8, 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Woodlawn Md

DATE OF BURIAL 12/11 1923

20 UNDERTAKER H. Staley Mount Washington

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81574

CERTIFICATE OF DEATH.

3/ D 81574

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 N. Wolfe ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Gibson

(Residence in Baltimore: No. 1033 N. Wolfe st St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1900 (Year)

7-AGE, 23 yrs. 4 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0'3

9-BIRTHPLACE, (State or Country), Annapolis Md.

PARENTS.

10-NAME OF FATHER, Fredrick Hebron

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mamie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant)..... William Gibson (Husband)

(Address)..... 1209 Mc Elderry St.

15- Rec'd DEC 9 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1923, to Dec 6 1923, that I saw h ew alive on Dec 4 1923, and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(Duration)..... 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.

12/8, 1923. (Address) 1429 E. Fayette st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec 9th, 1923

20-UNDERTAKER Walter Davis — ADDRESS 318 N Eden

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81575

CERTIFICATE OF DEATH.

D 81575

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1735 Covington St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Schneider

(a) Residence No. 1735 Covington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: William Schneider

6-DATE OF BIRTH (month, day and year): July 30 1868

7-AGE: 55 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Karle Hoppel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Schafer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mr. William Schneider

(Address): 1735 Covington

15- Filed DEC 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-9-23

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to Dec 9 1923

that I last saw her alive on Dec 9 1923

and that death occurred, on the date stated above, at 3 30 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symp.

(Signed) Sidney H. Streett M. D.

12/9/23. (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New York Bay Cemetery

DATE OF BURIAL: 12/12 19 23

20-UNDERTAKER: J. Frew McCully ADDRESS: Jersey City 130 E. Fort.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81576

CERTIFICATE OF DEATH.

D 81576

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2452 Eager Place ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bikirch

(a) RESIDENCE NO. 2452 Eager Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony J. Bikirch

6 DATE OF BIRTH (month, day, and year) Feb. 6 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Leonard Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Smithoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Beck

(Address) 2452 Eager Place

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Dec 6 1923 that I last saw h alive on Dec 6 1923 and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Rytzcha, M. D.

Dec 9 1923 (Address) 800 N Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Dec. 10 1923

20 UNDERTAKER Lilly and Zeller ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81577

X 86-001

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kraft

(a) RESIDENCE NO. Benzies P.O. Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 26-1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City.

PARENTS

10 NAME OF FATHER: Caspar Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City.

12 MAIDEN NAME OF MOTHER: Lena Peuth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. City.

14 Informant: Caspar Kraft.

(Address): Benzies P.O. Md.

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1923. to Dec 5, 1923.

that I last saw him alive on Dec 5, 1923,

and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Otitis Media (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Benzies, Md.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Brain Puncture Typical Evidence

(Signed) Geo. B. Gilbert M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Dec. 10 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 1103 S Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81578

CERTIFICATE OF DEATH.

2 D 81578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3612 Fait Ave. ST., 26 WARD)

2-FULL NAME Elana J. Eads.

(a) RESIDENCE NO. 3612 Fait Ave ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Curtis Eads.

6 DATE OF BIRTH (month, day, and year): Jan 5-1894

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: William Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Martha Mayburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Curtis Eads.

(Address): 3612 Fait Ave

15 DEC 10 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 1, to Dec 9/23, 19 14.

that I last saw h[illegible] alive on Dec 5th/23, 19 3

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 4 mos 9 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cypromator Va.

DATE OF BURIAL: Dec. 12 1923

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81579

CERTIFICATE OF DEATH.

X D 81579

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Gordy

(a) RESIDENCE NO. Delmar Del ST., ~~Md~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ross Gordy

6 DATE OF BIRTH (month, day, and year) Jan 26 - 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Thomas R. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Letetia Collins

13 BIRTHPLACE OF MOTHER (city or town) Del. (State or country)

14 Informant Husband - Ross Gordy -

(Address) Delmar Del

DEC 10 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1923, to Dec. 9, 1923,

that I last saw h er alive on Dec - 9, 1923,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

Bronchial Pneumonia -

CONTRIBUTORY (Secondary) (duration) Foreign body in left Bronchus yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov. 23 23

Was there an autopsy? yes

What test confirmed diagnosis? Clinical signs -

(Signed) R. Heller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delmar Delaware — DATE OF BURIAL Dec - 10 1923

20 UNDERTAKER Hall & Timmons — ADDRESS Delmar

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81580

D 81580

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Pamela ST., 16 WARD)

2-FULL NAME John Johnson

(a) RESIDENCE NO. 810 N. Pamela ST., WARD

(Usual place of abode) ditto

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mary Johnson deceased

6 DATE OF BIRTH (month, day, and year) not known — 1870

7 AGE: 53 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day labor

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Amy Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant: Ella Warfield

(Address): 1402 N. Bruce St.

15 Filed DEC 10 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7- 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5- 1923, to Dec. 6- 1923, that I last saw him alive on Dec. 6- 1923, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

about 3

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Hist. & Microscopic

(Signed) Chas. Little Cotton, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 10 1923

20 UNDERTAKER: Jos. A. Farrell — ADDRESS: 2319 Glenmore

52

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81581

CERTIFICATE OF DEATH.

38 D 81581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Scheller

(a) RESIDENCE NO. Mt Hope Retreat ST., 25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Scheller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	49	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer) Baking -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Scheller

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kramer

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Germany -

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1921, to Dec. 5th, 1923, that I last saw him alive on Dec. 5, 1923, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Paresis (Luetic)

abt (duration) 2 yrs. 6 mos 0 ds.

CONTRIBUTORY (Secondary) Paretic Psychosis abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted, if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Slaman, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec 11 1923

20 UNDERTAKER Geo. F. Rua

ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81582

CERTIFICATE OF DEATH.

90 D 81582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2654 Boone ST., 9 WARD)

2-FULL NAME George D WILLIAMS

(a) RESIDENCE No 2654 Boone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eddie C. Williams

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Expressman
(b) General nature of industry, business, or establishment in which employed (or employer) (self)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Phillip Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Anna Franklin Williams
(Address) 2654 Boone St.

15 Filed DEC 10 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Valvular Insuffiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Pacca M. D.
(Coroner.)

Dec 8/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec. 10 1923
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81583

CERTIFICATE OF DEATH.

90 D 81583

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 East ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Gaines

(Residence in Baltimore: No. 224 East St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 6, 1873
(Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Freddie Gaines

(Address) 224 East Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923, to Dec 3 1923, that I saw her alive on 1923, and that death occurred, on the date stated above, at 7:40 A m.

The CAUSE OF DEATH* was as follows:

Calcified Lesion of the Heart

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. G. Gardner M. D.

12/4, 1923. (Address) 918 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Cemetery

DATE OF BURIAL, Dec 10, 1923

20-UNDERTAKER Mrs R. C. Elliott

ADDRESS 1723 Ashland Ave

DEC 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81584

CERTIFICATE OF DEATH.

100-001
100 D 81584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 6 WARD)

2-FULL NAME John Thomas

(a) RESIDENCE No 223 N. Duncan St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/c yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): Mar 10/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	49	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: common

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Abbie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. R.A.Elliott
(Address): 1725 Ashland Ave

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia-lt lower & mid lobes-Primary
Autopsy at Hospital

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Wallis, M. D.

Dec 8/23, 192 (Address) 708 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Back River Cemetery	Dec 11 1923
20 UNDERTAKER: Mrs R.A. Elliott.	ADDRESS: 1725 Ashland Ave

Spec. 6-3-19 H. P. Co. 1000 Blks.

D 81585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81585

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 616 Carlton St. 16 WARD)

2-FULL NAME Edward Payne

(a) RESIDENCE. No. 616 Carlton St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: Colored 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887.

7 AGE: Years 36 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore Md.

10 NAME OF FATHER William Payne.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Matthews

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

PARENTS

14 Informant Sarah Payne (Address) 616 Carlton ave

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th 1923, to Dec 7th 1923

that I last saw h[illegible] alive on Dec 6th 1923

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. 6 mos. [illegible] ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. N. Lauterbach M. D.

Dec 8th 1923 (Address) 2215 N. Mont. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 12-11-1923

20 UNDERTAKER: David Carlson

ADDRESS 916 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lueti

Spec. 1-10-21 M&T 1500 Bks.

(Elizabeth Moseley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81586

D 81586

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Eliz. Moseley ST., 17 WARD)

2-FULL NAME 411 Pine St.

(a) RESIDENCE NO. 411 Pine St. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. R. Moseley

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer Victoria Theatre

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Both Wilby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. County

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto County

14 Informant Chas. R. Moseley.
(Address) 411 Pine St.

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1923, to Aug 8th, 1923.

that I last saw her alive on Aug 4th, 1923,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of the liver
Contributory Metastasis
Carcinoma since the tumor
Tongue Back, Upon the diet
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chew, M. D.

(Address) 724 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Chew

DATE OF BURIAL 12/12/1923

20 UNDERTAKER Daniel Tarbert

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D 81587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 132 D 81587

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3rd Gen Hosp ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida V. De Atley

(a) RESIDENCE NO. 3406 Piedmont Ave ST., WARD Washington DC.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carroll De Atley

6 DATE OF BIRTH (month, day, and year) Jan 31, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Wash D. C

PARENTS

10 NAME OF FATHER John J. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Carroll De Atley

(Address) 651 W. Franklin

15 DEC 10 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-23

17 I HEREBY CERTIFY, That I attended deceased from 11-18-23 19 , to 12-9-23, 19 ,

that I last saw h alive on 12-9-23, 19 ,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Renal Calculus 6 Mos

Pyonephrosis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia Pyelitis

(duration? yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 11-26-23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Surgical

(Signed) Jno A Topper M. D.

12/9. 1923 (Address) 20 W Centre St

*State the Disease Causing Death, In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec 12 1923

20 UNDERTAKER Mr & Mrs John W. Teufel & Son

ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 10ks.

D 81588

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 81588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 So. Bond ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Truszkowska

(a) RESIDENCE NO 622 So. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walter Truszkowska
(Address) 512 So. Washington st

15 Filed DEC 10 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

(Signed) Jno. B. Horton M. D.
(Coroner)
Dec 9, 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 11 192 3

20 UNDERTAKER F. H. Ozmun & Son ADDRESS 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81589

D 81589

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Mura ST., 8 WARD)

2-FULL NAME Carl B. Rusch

(a) RESIDENCE NO. 2222 Mura ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizetta Reine

6 DATE OF BIRTH (month, day, and year) Nov 16 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Polisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hoen Bro.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Benj Rusch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lizetta Rusch

(Address) 2222 Mura St

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Dec. 7, 1923, that I last saw him alive on Dec. 7, 1923, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) General Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? X Ray, Examination

(Signed) Albert Bingemann, M. D.

12/9/, 1923 (Address) 613 E Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: John Leerich

ADDRESS: 2008 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81590 — 188-003 — D 81590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kalbskopf

(a) RESIDENCE No 2242 E. North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Abbreviations not to be used. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Kolbskopf

6 DATE OF BIRTH (month, day, and year) Dec 12/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer Mr. Turner

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Kalbskopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Kalbskopf
(Address) 1830 E. Biddle St

15 DEC 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Oedema of Glottis -
Secondary infection scalp wound
Automobile accident Nov 30/23
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Patten, M. D. (Coroner.)

Dec 8/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 10 1923

20 UNDERTAKER Geo C Miller — ADDRESS 2337 Jefferson St

D 81591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81591

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Bon Secours Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Anna L. Cross,

(Residence in Baltimore: No. 543 N. Pulaski St.; yrs. 44 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced? (Write the word.): Married

6-DATE OF BIRTH: July (Month) 12 (Day) 1879 (Year)

7-AGE: 37 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Typeist
(b) General nature of Industry, business, or establishment in which employed (or employer): Jones & Griffith Co

9-BIRTHPLACE (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Edward J. Cross

11-BIRTHPLACE OF FATHER. (State or Country): Baltimore City

12-MAIDEN NAME OF MOTHER: Catherine Connor

13-BIRTHPLACE OF MOTHER. (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Cross

(Address) 543 N Pulaski St.

15-

DEC 10 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Fracture of Skull

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Shock

Duration ..... yrs. ..... mos. 1 ds.

(Signed) Geo Claude Stadel M. D.

(Coroner)

Dec 9 1923 (Address) 1436 Bray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Dec. 11 1923

20-UNDERTAKER: Martin Lukey Sons ADDRESS 1827 W North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 81592

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 81592

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Singer Av ST.: 21 WARD)

2-FULL NAME James Stant-Amacost

(a) RESIDENCE. No. 6 Singer Av ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms. Abbreviations should be stated EXACTLY. PHYSICIANS should state which is very important. See instructions on back of certificates. TION

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel T. Amacost

6 DATE OF BIRTH (month, day, and year) June 26-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James T. Amacost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ethel T. Amacost
(Address) 6 Singer Av

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar
DEC 10 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 7, 1923, that I last saw ~~him~~ alive on Dec 7, 1923, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Fatty heart w/ Acute dilatation

(duration) — yrs. — mos. Few hours.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) C. B. Ensor, M. D.

12-9 1923 (Address) 5016 Park Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Dec 10 1923

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 502 Madison Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81593 ✓ D 81593

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 405 W. 24th St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Grace Tonnell Benson

(a) RESIDENCE. No. 405 W. 24th St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarence Benson

6 DATE OF BIRTH (month, day, and year) Dec 12 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John H Grundell

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Alice Elliott

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Clarence Benson.
(Address) 406 W 24 St.

DEC 10 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to Dec 7, 1923, that I last saw her alive on Dec 7, 1923, and that death occurred, on the date stated above, at 10,12 a m.

The CAUSE OF DEATH* was as follows:

E Pancreas
(duration) yrs. Few mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (duration) yrs. Few mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Dec 8 23 (Signed) C A Richardson, M. D.
, 19 (Address) 1120 W. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 10 1923
20 UNDERTAKER	ADDRESS
M Luby & Sons.	1823 W Pratt

INSTRUCTIONS.—WRITE LEGIBLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 81594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 81594

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1433 Main st Mt Winans ST. 25 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Magness

(a) RESIDENCE. No. 1433 Main st Mt Winans ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Maryland

PARENTS

10 NAME OF FATHER William Magness

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wagner

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Maryland

14 Informant George N Powell
(Address) 707 Scott st

15 DEC 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8- 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 . 1923 . to Dec 7 . 1923 .

that I last saw her alive on Dec 7 . 1923 .

and that death occurred, on the date stated above, at 7-55- a m

The CAUSE OF DEATH* was as follows:

arteria sclerosis chronic
Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Z Boyle, M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Run Cem Harford Co Md	Dec 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81595

CERTIFICATE OF DEATH.

111 D 81595

REGISTERED NO.

1-PLACE OF DEATH Bon Secours Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Fayette E Dayson ST., 18 WARD)

2-FULL NAME Mrs. Florence Walsh

(a) RESIDENCE No. 719 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry H. Walsh

6 DATE OF BIRTH (month, day, and year) Oct 28, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Maurice Leeson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rachel Ridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Maurice Walsh

(Address) 719 W Lexington

15 Filed DEC 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10th, 1923, to Dec. 8th, 1923, that I last saw h.. alive on Dec. 9th, 1923, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Pyloric stenosis with gastric dilitation and cachexia.

(duration) — yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Ulcer of pyloric with cicatrization (duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Dec. 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical X ray exam.

(Signed) H W Bonsee M. D.

12/9/1923 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 11 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

INFORMATION TO BE GIVEN BY PERSONS FILING CERTIFICATES. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. WRITE CAREFULLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81596

CERTIFICATE OF DEATH.

3 D 81596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis St., Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Byrnes

(a) RESIDENCE NO. 1427 E. Chase ST., WARD City

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years about 67 Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Orderly

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland U. S. A.

PARENTS

10 NAME OF FATHER John Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Agnes McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Daughter Katie Hyman 1042 Hartford Ave.

15 Filed ..., 19... ROBERT P. KRAUTER, Registrar

Burial Permit Clerk

DEC 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1923, to Dec 8, 1923, that I last saw him alive on Dec 8, 1923, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lawrence Selby, M. D.

, 19 (Address) Municipal Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pancras Cemetery — DATE OF BURIAL: Dec. 12, 1923

20 UNDERTAKER: Henry Hoch Son — ADDRESS: 1301 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81597

CERTIFICATE OF DEATH.

21 D 81597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 598-W-Preston St ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Butler

(a) RESIDENCE NO. 598 W. Preston ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug-28-03

7 AGE — Years: 20 — Months: 3 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James L Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Jessie Cooley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Rose Butler (Address) 598 W Biddle St

15 DEC 10 1923 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1923, to December 6, 1923, that I last saw him alive on December 5, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 9 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Health Department

(Signed) D. L. W. Kennard, M. D.

12-7, 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 12/10 1923

20 UNDERTAKER: Samuel Hensley

ADDRESS 528 N Biddle

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81598

D 81598

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Jackson

(a) RESIDENCE NO. 766 W. Mulberry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Jackson

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Catherine Kalbaugh

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1923

17

I HEREBY CERTIFY, That I attended deceased from November 19, 1923, to December 6, 1923,

that I last saw him alive on December 6, 1923,

and that death occurred, on the date stated above, at 4:35 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Chronic Nephritis

Myocardial degeneration

(duration) yrs. 6 mos (?) ds.

CONTRIBUTORY (Secondary) Uremia (Terminal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude 9 Moore, M. D.

12-7-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 12/11 23

20 UNDERTAKER Samuel T. Hensley

ADDRESS 1738 N. Eddn

IMPORTANT—WRITE CAREFULLY AND DO NOT OMIT ANY INFORMATION. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks

D 81599

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

14 | D 81599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 22 WARD)

2-FULL NAME Mary Sankus

(a) RESIDENCE No. 539 W. Barre St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuanian

PARENTS

10 NAME OF FATHER William Sankus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuanian

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address)

DEC 10 1923

Filed ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 6, 19 23, to December 7, 19 23, that I last saw h er alive on December 7, 19 23, and that death occurred, on the date stated above, at 10:10 A M.

The CAUSE OF DEATH* was as follows:

Senile Retrogression

Prolapsus Uteri

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A Pierce, M. D.

12-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec. 11 19 23

20 UNDERTAKER John Gebliecuckus

ADDRESS 425 S. Fond

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81600

CERTIFICATE OF DEATH.

X 86 1908 81600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Genl Hospital ST., 24 WARD)

2-FULL NAME Meredith DeGrange

(a) RESIDENCE No. Linthicum Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2. 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11 -	7	- 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland.

PARENTS

10 NAME OF FATHER John DeGrange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Maryland

12 MAIDEN NAME OF MOTHER Laura Richter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Maryland

14 Informant H. M. Hartline

(Address) Linthicum Heights,

15 Filed DEC 1 0 1923 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 9 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 9, 1923,

that I last saw him alive on Dec 9, 1923,

and that death occurred, on the date stated above, at 2 55 P. m.

The CAUSE OF DEATH* was as follows:

Otitis Media

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? no Date of

Was there an autopsy? no Clinical signs - Symptoms

What test confirmed diagnosis? Spinal puncture.

(Signed) W. Pratt Coolidge M.D.

12-10-1923 (Address) Linthicum Hts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co.	DEC 11 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Leigh St

X.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81601

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D 81601

REGISTERED No. C

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1801 Chilton St. ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine Schlemmer Obrecht

(Residence in Baltimore: No. 1801 Chilton St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: August (Month) 23 (Day), 1868 (Year)

7 AGE: 55 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frederick Schlemmer

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Klump

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta E. Shanks (Daughter)

(Address) 1619 E. 33rd St.

15 Filed DEC 10 1923, 191... ROBERT R. KRAUTER, REGISTRAR

Burial Permit (illegible)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 7 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓4, 1923, to Dec 7 1923, that I saw h[illegible] alive on Dec 6, 1923, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis - arterio-sclerosis - taken to bed Nov 1st 1923

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Lac. dilatation of heart 4 months

(Duration) yrs. mos. ds.

(Signed) Fernando [illegible] M. D.

, 191... (Address) 704 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted. If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 10 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec. 1-19-23 M&T 1500 lbs.

B 81602

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 B 81602

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lumpkins

(a) RESIDENCE NO. 513 S Green St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 22 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Lumpkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lillie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1923, to Dec 9, 1923, that I last saw h[illegible] alive on Dec 9, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood Wassermann +

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Dec 10 1923

20 UNDERTAKER Geo. A. Hofer — ADDRESS 506 N. Conway St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Dodd

B 81603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 B 81603

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1402 E. Madison ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isiah Dodd

(Residence in Baltimore: No. 1402 E Madison St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month) unknown (Day) ..... (Year) 1867

7-AGE, Yrs. Approx 56 yr Mos. ..... Ds. .....

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Mark Dodd.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Johnston (Friend)

(Address) 1412 Argyle Ave

15-

Filed DEC 10 1923 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923, to Dec 7 1923, that I saw him alive on Dec 6 1923, and that death occurred, on the date stated above, at 2.46 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(now tubercular) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.

Dec 7, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cashmy Cemetery

DATE OF BURIAL, Dec. 10th, 1923

20-UNDERTAKER Mrs. R. C. Elliott

ADDRESS 1125 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81604

CERTIFICATE OF DEATH.

188-003

D 81604

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., (WARD)

2-FULL NAME John A. Siebert

(a) RESIDENCE NO 1410 E. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Siebert

6 DATE OF BIRTH (month, day, and year) May 13th 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Siebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lorina Dachs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elz. Siebert
(Address) 1410 Lafayette

15 Filed DEC 10 1923 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest at this time find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism
following fract tibia & fibula
struck by automobile.
and 12 hours (Duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) At this time doubt whether accidental or not
Duration yrs. mos. ds.

(Signed) H. T. Athey M. D. Staff nurses M. D.
(Coroner.)

Dec 7 1923 (Address) 1639 Linn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 11th 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E. Monument St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81605

CERTIFICATE OF DEATH.

100-001

D 81605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Fifteenth ST., 7th WARD)

2-FULL NAME Edward Haupt.

(a) RESIDENCE NO. 330 S. Fifteenth ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Haupt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Millholand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant William Wall.

(Address) 330 S. Fifteenth St.

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1923 to Dec 9 1923

that I last saw him alive on Dec 8 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchial Pneumonia (duration) X yrs. X mos. 1 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? history

(Signed) Jas. L. Truax, M. D.

Dec 9, 1923 (Address) 218 So 39 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral — DATE OF BURIAL: Dec 10th 1923

20 UNDERTAKER: Lilly & Feiler — ADDRESS: 401 S. Eden St.

I. B. MARK PLAINLY, WITH INDELIBLE INK—THIS STATEMENT IS RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Wisner, 2112 Maryland Ave

D 81606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81606

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH 141 East North Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Mary A. Steve

(a) RESIDENCE NO. 141 E North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis M Steve

6 DATE OF BIRTH (month, day, and year): April 27 1868

7 AGE — Years: 54 Months: 7 Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michall Dignan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Lewis M Steve

(Address): 141 E North Ave

15 Filed DEC 10 1923 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12 - 1923, to Dec. 9. 1923.

that I last saw h[illegible] alive on Dec. 8 - 1923

and that death occurred, on the date stated above, at 3:30 a. m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos 28 ds.

CONTRIBUTORY (Secondary) Mitral Insuf. cardiac hypertrophy (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Edward Wisner, M. D.

12/10 1923 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: Dec 12, 1923

20 UNDERTAKER: Wm. Cook & Co. — ADDRESS: [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81607

CERTIFICATE OF DEATH.

44D 81607

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3527 Gough St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John C. F. Schneider

(a) Residence No. 3527 Gough St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or ~~WIFE of~~) Katherine Lukemire

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer). 015

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Katherine Schneider

(Address) 3527 Gough

15- Filed ....., 19.. Registrar.

ROBERT P. KRAUTER

DEC 10 1923

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1923 to Dec 8 1923

that I last saw h[illegible] alive on Dec 8 1923

and that death occurred, on the date stated above, at 8.25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. C. Long M. D.

12/9, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakdawn — DATE OF BURIAL, 12/11, 1923

20-UNDERTAKER. Ivy Cook — ADDRESS 502 E North

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81608

CERTIFICATE OF DEATH.

12 D 81608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Mace Ave ST. [illegible] WARD 20)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hayes Purdie

(a) RESIDENCE NO. 4000 Mace Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta C. —

6 DATE OF BIRTH (month, day, and year) March 25 1843

7 AGE Years 80 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Eng Canada

PARENTS

10 NAME OF FATHER John Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ellen Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Chas. G. Purdie

(Address) 4000 Mace Ave

15 Filed DEC 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to Dec 9, 1923

that I last saw h— alive on Dec 5, 1923

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Natural Senescence

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interstit nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M A Purdie, M. D.

12/9, 1923. (Address) Irvington —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL 12/11 1923

20 UNDERTAKER Wm Cook 502 E. Fay. Ave. ADDRESS

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81609

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

2-FULL NAME Adam Prehowlef

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address)

15 Filed DEC 10 1923 ROBERT P. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from December 4, 1923, to December 6, 1923,

that I last saw him alive on December 6, 1923,

and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, (Degenerative)
Auricular Fibrillation
Myocardial Insufficiency

(duration) yrs. 1 mos (Autopsy)

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Grace, M. D.

12-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	12/10/23.
20 UNDERTAKER	ADDRESS
L. F. Fahey & Sons	1318 Light St

Spec.—1-10-21—M&T—1500 Blks.

Wiskeman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81610

CERTIFICATE OF DEATH.

113 D 81610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Keyser ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earnestine M. Wiskman

(a) RESIDENCE No. 1608 Keyser ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 - 1923

7 AGE: Years — Months 8 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md

PARENTS

10 NAME OF FATHER Harvey A. Wiskman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Margaret L Gibson

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) DC

14 Informant Margaret L Gibson (Address) 1608 Keyser st

15 Filed DEC 10 1923 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1923, to Dec 9th, 1923, that I last saw her alive on Dec 9th, 1923, and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1502 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: Robt J Turner Sr — ADDRESS: 1492 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81611

CERTIFICATE OF DEATH.

14001

D 81611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Truer

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 10 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from October 29, 1923, to December 9, 1923, that I last saw h im alive on December 9, 1923, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Right Hemiplegia (Hemorrhage)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (Terminal) Broncho Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) Claude G. [illegible], M. D.

12-12-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew | DATE OF BURIAL: Dec. 10 1923

20 UNDERTAKER: Jack Kraus, | ADDRESS: 1639 E Balto.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81612

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 13 WARD)

2-FULL NAME Charles Fitzpatrick

(a) RESIDENCE NO. 190 Cedar Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 31 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~54~~ 52	8	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Dealer (Wholesale)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Patrick Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kate Sangney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Curry (Address) 190 Cedar ave

15 Filed DEC 10 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 19 23 to Dec 9 19 23

that I last saw h[illegible] alive on Dec 9 19 23

and that death occurred, on the date stated above, at 4 11 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) John A. Scheurich M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Dec. 12 19 23

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.N.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81613

CERTIFICATE OF DEATH.

101-001 D 81613

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2919 Westwood St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia D. Wehrheim

(a) Residence No. 2919 Westwood St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Wehrheim

6-DATE OF BIRTH (month, day and year): March 16th 1901

7-AGE: 22 yrs. 8 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework. Dy

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Owen C. McLaughlin

11-BIRTHPLACE OF FATHER (city or town) Ireland. (State or Country),

12-MAIDEN NAME OF MOTHER, Mary T. Boyle

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

11- (Informant) Marie McLaughlin

(Address) 1917 Riverside Ave

15-

Filed DEC 10 1923 19?? ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): December 8. 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2 1923 to Dec 8 1923

that I last saw h[illegible] alive on Dec. 7. 1923

and that death occurred, on the date stated above, at 8 15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) ... yrs. 4 mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens M. D

12/8, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL, Dec. 11 1923

20-UNDERTAKER: Margaret F. Flynn ADDRESS: 1422 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81614

CERTIFICATE OF DEATH.

160 D 81614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 S. Sharp St., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Shea

(a) RESIDENCE No. 1240 S. Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept. 30, 1923

7 AGE: ✓ Years | 2 Months | 10 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Edward Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine Moylan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant: Mrs. Shea (mother)

(Address): 1240 S. Sharp St

15 Filed ..., 19 ... Registrar

ROBERT E. KRAFFERT

Burial Permit Clerk.

DEC 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 23, to Dec 10, 1923, that I last saw him alive on Dec 9, 1923, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) yrs. mos 8. ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. 2. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of..

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thaumet Wheeler, M. D.

, 19 (Address) Lakeland, Landsdowne P.O. Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem

DATE OF BURIAL: Dec. 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1 [illegible] Light

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81615

CERTIFICATE OF DEATH.

73 D 81615

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Bruce St. ST., 19 WARD)

2-FULL NAME John E. Eisenhauer

(a) RESIDENCE NO. 224 S. Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the Late Rachael Eisenhauer

6 DATE OF BIRTH (month, day, and year) January 10, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ------- Eisenhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John W. Eisenhauer Jr.
(Address) 224 S. Bruce St.

15 Filed DEC 10 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1922, to Dec. 7th, 1923, that I last saw h alive on Dec. 7th, 1923, and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myelitis of the Anterior Horns of the Cord -

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O. L. Mackobee M. D.

, 19 (Address) 130 S. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dayton Park — DATE OF BURIAL Dec 10 1923

UNDERTAKER Harry H. Loitz & Co — ADDRESS 1531-43 Lombard St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81616 CERTIFICATE OF DEATH.

D 81616

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi McDuffie

(a) RESIDENCE NO. 625 N Eutaw ST

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

WARD ... (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	-	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. A. McDuffie

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Addie A. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant ... (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

DEC 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2-, 1923, to Dec 8-, 1923

that I last saw her alive on Dec 8-, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Born at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) N. H. Mech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Dec 8 1923

20 UNDERTAKER Commissioner Health,

ADDRESS

per WM. E. WOODALL.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

168136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81617

CERTIFICATE OF DEATH.

16-001

16 D 81617

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Maloney Mc Duffie

(a) RESIDENCE No. 825 W. Dunham St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Our life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Dec 1, 1923

7 AGE — Years: — Months: — Days: 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 800

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William H. Mc Duffie

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Addie J. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Records
(Address) JOHNS HOPKINS Hosp. JOHNS HOPKINS HOSPITAL

15 DEC 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 6, 1923, that I last saw her alive on Dec 6, 1923 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. life mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Born at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mead, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: Dec 8 192.3

20 UNDERTAKER: Commissioner Health, — ADDRESS

Per. Wm E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

372

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81618

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 1225 Penna Ave St., 17 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Prater

(a) Residence No. 1225 Penna Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 16 1904

7-AGE, 19 yrs. mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:

10-NAME OF FATHER, Edwd Prater

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Posey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Annie Prater

(Address) 1225 Penna Ave

Filed DEC 10 1923 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 8 23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec 8, 1923, that I last saw h[er] alive on Dec. 7, 1923 and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Thos E. Pagan M. D.

12 (Address) 106 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Frgt Auburn Cem DATE OF BURIAL, 12-10 1923

20-UNDERTAKER George T. A. Gibbons ADDRESS 1335 Pine Ave Hilton

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No history
Pulmonary Tuberculosis
3 yrs.

Spec.—1-10-21—M&T—1500 Bks.

Ruvolazzo

D 81619

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

D 81619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Mc Elderry St., 5 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pietro Ruvolazzo

(a) RESIDENCE No. 1215 Mc Elderry St. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER Giorgio Ruvolazzo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Laura Costerbo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Giorgio Ruvolazzo
(Address) 1215 Mc Elderry St

15 Filed DEC 10 1923 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17
I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to Dec 8, 1923,
that I last saw him alive on Dec 8, 1923,
and that death occurred, on the date stated above, at 1-4 m.
The CAUSE OF DEATH* was as follows:

Bronco. Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

, 19 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 12/10/23

20 UNDERTAKER Geo. J. Ruth — ADDRESS 1735 Hanford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81620

74-90 ✓ D 81620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 706 George St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Henderson

(a) Residence No. 706 George St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Col. 5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Archer

6-DATE OF BIRTH (month, day and year) June 1866

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Don't Know

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Nettie Malden

(Address) 706 George St.

15- Filed DEC 10 1923 192... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8, 1923

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923 to Dec 8, 1923

that I last saw her alive on Dec 7, 1923

and that death occurred, on the date stated above, at 11-9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —?

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Moore M. D.

, 19 (Address) 753 George

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL, Dec 11 1923

20-UNDERTAKER J L Brown & Son ADDRESS 108 N Howard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81621

CERTIFICATE OF DEATH.

1886 1003 D 81621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Lipscomb

(a) RESIDENCE NO. 728 W Mulberry St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-26-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Herman Gruics

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lillie Lipscomb

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lillie Lipscomb
(Address) 728 W Mulberry St

15 Filed DEC 10 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest au-~~ ~~topsy or inquiry.)~~ find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & crushed Chest

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(duration) yrs. 2 mos. ds.

(Signed) W K Greenlee, M. D.
(Coroner)

12-10, 1923 (Address) 1711 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Auburn	Dec 11 1923
20 UNDERTAKER	ADDRESS
J L Brown Son	108 Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81622

CERTIFICATE OF DEATH.

44 D 31622

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 604 Parkwyrth Ave. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Hill

(a) Residence No. 604 Parkwyrth Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie K. Hill

6-DATE OF BIRTH (month, day and year) Oct. 29 1853

7-AGE. 70 yrs. 1 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Potter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md. (State or Country).

PARENTS.

10-NAME OF FATHER, Major Hill

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country).

12-MAIDEN NAME OF MOTHER, Sarah A. Wheeler

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country).

14- (Informant) Milton K. Hill

(Address) 604 Parkwyrth Ave.

15- Filed DEC 10 1923 ROBERT E. KRAUTH, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/8-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1923 to Dec 8 1923

that I last saw him alive on Dec 7 1923

and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) yrs. mos. 4d ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 31/23

Was there an autopsy?

What test confirmed diagnosis? Exploratory Laparotomy

12/10 1923 (Signed) Abm. P Leeman M. D

(Address) 718 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. 12/12 1923

20-UNDERTAKER. J. Fen McCully ADDRESS 130 E. Fort

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81623

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3903 (St.) Halls Road (Ward) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah J. Hilson

(a) RESIDENCE No. 3903 Halls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph F. Hilson

6 DATE OF BIRTH (month, day, and year): Feb 14-1843

7 AGE: Years 80 Months 9 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: Geo. Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rachael Pearce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Joseph F. Hilson 3903 Falls Road

DEC 10 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Dec 8, 1923,

that I last saw h(e) alive on Dec 8, 1923,

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary): Valvular disease of Heart

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. B. Norbert, M. D.

12. 9. 1923 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 463 Falls Rd.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81624

CERTIFICATE OF DEATH.

31 ✓

D 81624

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3742 Hickory Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard L. French

(Residence in Baltimore: No. 3742 Hickory Ave St.; 27 yrs., 1 mos. 16 ds.)

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct. 23, 1896 (Month) (Day) (Year)

7-AGE, 27 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo. F. French

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Rosie L. Chaffman

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. French

(Address) 3742 Hickory Ave.

15- DEC 10 1923 ROBERT R. KRAUTER,

Filed....., 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1923, to Dec 9 1923, that I saw h im alive on Dec 8 1923, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Pulmonary Th

(Duration) ? yrs. ....mos. ....ds.

(Signed) C. L. Hemsteis M. D.

12/10, 1923 (Address) 733 Ausquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's, Hyattsville | DATE OF BURIAL, Dec. 11, 1923

20-UNDERTAKER Horace F. Burgee | ADDRESS 1631 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81625

74 D 81625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Christs Institution Hospital ST., 17 WARD)

2-FULL NAME Mollie Roberts

(a) RESIDENCE NO. 1220 Etting St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Benjamin Roberts

6 DATE OF BIRTH (month, day, and year) Dec. 1853

7 AGE: Years 70 Months — Days — If LESS than 1 day, hrs or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. Not Known

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Benjamin Roberts

(Address): 1220 Etting St.

15 [illegible] 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

C 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 8 1923

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1923 to December 8, 1923.

that I last saw her alive on December 8, 1923

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Paralysis & complication of Disease (duration) yrs. 6 mos. 10 ds.

18 Where was disease contracted if not at place of death? 1220 Etting St Balto Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Gill Kennard M. D.

12-8, 1923 (Address) 708 Union St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

20 UNDERTAKER: Jos. M. Johnson

DATE OF BURIAL: Dec. 12 1923

ADDRESS 1309 Druid Hill

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81626

D 81626

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Church Home & Inf 6

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Walker

(a) RESIDENCE NO. Church Home & Inf ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John K. Walker

6 DATE OF BIRTH (month, day, and year) July 1 1841

7 AGE: Years 82 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Tolson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Gifford

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Church Home & Infirmary

(Address) Fairmount Ave & Broadway

15 Filed DEC 10 1923, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 19 23

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 19 23, to Dec 8, 19 23,

that I last saw her alive on Dec 8, 19 23,

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Nitrus sclerosis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. C. Rice, M. D.

19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 12/10 19 23

20 UNDERTAKER: H E Stughel

ADDRESS: 42nd St. & Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-21—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81627

CERTIFICATE OF DEATH.

D 81627

90

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. S.W.cor Hanover & Pratt St. ST., S 10 WARD)

2-FULL NAME John P.Gibson.

(a) RESIDENCE No 923 Valley St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced (HUSBAND OF) Mary A Gibson.

6 DATE OF BIRTH (month, day, and year) October 3, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman in 017
(b) General nature of industry, business, or establishment in which employed (or employer) Cigar factory
(c) Name of employer Krauss & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Gibson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Gilhovley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary Gibson. (wife)
(Address) 923 Valley St.

15 Filed 101923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December, 8, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

Dec, 9, 192 3 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Dec. 12 1923

20 UNDERTAKER H. C. Redfield 914 Druid Pk — ADDRESS

Robert F. Garrison, Burial Permit Clerk.

TION is very important See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81628

D 81628

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 N. Charles ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Virginia Symes

(a) RESIDENCE. No. 2514 N Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (School) Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Jno A. Symes

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Boston~~ Virginia

12 MAIDEN NAME OF MOTHER Ann Eliz Claggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant Mrs. A. Symes

(Address) 2514 N Charles

15 Filed ..., 19... Robert P. Harrison,

Registrar

Special Permit Clerk.

C 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Dec 9, 1923, that I last saw h[illegible] alive on Dec 9, 1923, and that death occurred, on the date stated above, at 10 52 A m.

The CAUSE OF DEATH* was as follows:

Chronic ulcers legs-arteriosclerotic-Chronic nephritis

several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D J Kirby, M. D.

19 (Address) 1105 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12/11 19
20 UNDERTAKER	ADDRESS
Henry W. Kears & Son	805 N. Calvert

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 N. Calhoun St. 16 Ward) 197

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Gallop

(Residence in Baltimore: No. 806 N. Calhoun St. St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced (Write the word.): single

6-DATE OF BIRTH: Sept. (Month) (Day) 1902 (Year)

7-AGE: 21 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE (State or Country): N. C.

PARENTS

10-NAME OF FATHER: Josephus Gallop.

11-BIRTHPLACE OF FATHER (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: Maggie Jarvis

13-BIRTHPLACE OF MOTHER (State or Country): N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephus Gallop.

(Address) Jarvisburg, N. C.

15-

Filed DEC 10 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 5 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above. (autopsy)

The CAUSE OF DEATH* was as follows:

Gun shot wound of chest almost instantaneous

(Duration) yrs. mos. Decd

CONTRIBUTORY (Secondary) Homicide

(Duration) yrs. mos. ds.

(Signed) J. S. Hennessy, M. D. (Coroner)

Dec 10, 1923 (Address) 280 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Jarvisburg, N. C. DATE OF BURIAL: Dec 10 1923

20-UNDERTAKER: Sam'l H. Chase, Bro. ADDRESS: 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81630

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 E 33rd St ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Walter Lowson Jr.

(a) RESIDENCE NO. 1607 E. 33rd St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion S. Lowson

6 DATE OF BIRTH (month, day, and year) April 25th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hart & Crouse

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William W. Lowson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie E. Proctor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant William W. Lowson

(Address) 617 N. Broadway

15 Filed DEC 1 01923, 19

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Dec 9, 1923, that I last saw h[illegible] alive on Dec. 9, 1923, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition & Exhaustion

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Melena Sarcoma

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Lexington

Did an operation precede death? Yes Date (Nov. 1923 St Agnes Hospt)

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Jas F Kelly, M. D.

9, 1923 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 12 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hands of the Clock

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81631

38 D 81631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Petitt

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, Registrar

DEC 10 1923 , 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from December 26, 1916, to December 6, 1923.

that I last saw h im alive on December 5, 1923.,

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

C.N.S. Syphilis

Tabes dorsalis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Clark G. Druce, M. D.

12-7, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

Per. Wm. E. WOODALL

ADDRESS

DEC 10 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81632

CERTIFICATE OF DEATH.

185 D 31632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Durham ST., 6 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Rowland

(a) RESIDENCE NO. 212 N. Durham ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Rowland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Phelbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E Rowland
(Address) 212 N. Durham

15 ..... 19 ..... Registrar

C 101923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1923, to Dec 8, 1923, that I last saw h[illegible] alive on Dec 6, 1923, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Fract Rt Hip
Accident (over)

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Hyps. Pneumonia (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) E. L. Blades, M. D.

Dec 10, 1923 (Address) 1436 Bonney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 12/12/1923

20 UNDERTAKER E. J. Fanning & Son - 1936 — ADDRESS Lafayette Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall down
Stairway at Home

Spec.—1-10-21—M&T—1500 Blks.

D 81633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81633

164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 W. Mosher St. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Giles

(a) RESIDENCE NO. 2812 W. Mosher St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Giles

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1825

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
98	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Noah Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Keturah M. Wallace

(Address) 2812 W. Mosher St.

15 Dec 1 1923 Robert F. [illegible]

Registrar

Burial Permit Clerk.

C 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1923, to Dec 9, 1923, that I last saw h alive on Dec 8, 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ralph Estergt M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hames Quarter Md.	Dec. 11 1923
20 UNDERTAKER	ADDRESS
Wm C. Black	922 N. Broadway

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81634

CERTIFICATE OF DEATH.

11-007 D 81634

1-PLACE OF DEATH

City of BALTIMORE: (No. 4007 Maine ave St., 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albert C. Hall

(a) Residence No. 4007 Maine ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of:

6-DATE OF BIRTH (month, day and year): Oct 23-1869

7-AGE. 54 yrs. 1 mos. 15 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:

(a) Trade, profession, or particular kind of work: Asst Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Colgers Public

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto.

PARENTS:

10-NAME OF FATHER: Charles Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Elinor O'Brien

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-(Informant) Elinor Hall

(Address) 4007 Maine ave.

15- Robert P. Harrison, 1923 Registrar.

C 1 01923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 8-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1923 to Dec. 8, 1923, that I last saw him alive on Dec. 8, 1923 and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lacerated Leg

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meredith Lovell M. D.

, 19 (Address) 3705 Liberty Hgts. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	Dec 11, 1923
20-UNDERTAKER.	ADDRESS
F. A. Hance & Son	703 Hanover St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 81635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81635

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Ettings ST.: 14 WARD)

2-FULL NAME. Jennie Harris

(a) RESIDENCE. No. 1803 Ettings ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE: 68 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Hanson Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Brooks

(Address) 1803 Ettings

C 101923

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Dec 10, 1923, that I last saw h[illegible] alive on Dec 9, 1923, and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible] M. D.

. 19 (Address) 2[illegible] Eutaw R.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	12-13 1923
20 UNDERTAKER	ADDRESS
George I. G. Eaton	1135 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D 81636 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 81636

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1321 N. Fulton Ave St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Ada Alvey.

(a) RESIDENCE No. 1321 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 20 1918

7 AGE — Years: 5. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Luther B. Alvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ada L. Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mr Luther B. Alvey

(Address) 1321 N. Fulton Ave

15 Robert P. Harrison, Registrar

16 Burial Permit Clerk.

C 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1923, to date of death

that I last saw her alive on date of death

and that death occurred, on the date stated above, at 2. A. m.

The CAUSE OF DEATH* was as follows:

Due to laryngeal diphtheria about 5 days duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Lee Davis M. D.

, 19 (Address) 724 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MXT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81637

CERTIFICATE OF DEATH.

100-00 D 81637

1-PLACE OF DEATH St Agnes Hosp

CITY OF BALTIMORE: (No. 2-0 ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Arthur K Spraker

(a) RESIDENCE No. 202 W. Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs A E Spraker

6 DATE OF BIRTH (month, day, and year) Mar. 12. 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
52	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Jacob Spraker

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country) " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Mrs Anna E Spraker

(Address) 202 W Fulton ave

15 Filed ..., 19 Robert P. Harrison, Registrar

EC 101923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 - , 1923, to Dec 8 , 1923, that I last saw h[illegible] alive on Dec 8 , 1923, and that death occurred, on the date stated above, at 3 15 am.

The CAUSE OF DEATH* was as follows: Bilateral Bronchopneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab + Phy Sig

(Signed) H W Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pgr Cathedral — DATE OF BURIAL Dec 11 1923

20 UNDERTAKER George L. Schwab — ADDRESS 2101 Eutaw Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Jester)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81638

CERTIFICATE OF DEATH

D 81638

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Masonville ST., Chesapeake Ave. WARD 25)

2-FULL NAME Rebecca J. Jester

(a) RESIDENCE No. Masonville ST., Chesapeake Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) at Shipyard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Anton Jester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Fannie Jester

(Address) Masonville Balto City

15 Filed DEC 10 1923 Robert P. Harrison, M.D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923, to Dec 9, 1923

that I last saw h alive on Dec 9, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Bronchitis 6 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Dec 9, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill | DATE OF BURIAL Dec. 12 1923

20 UNDERTAKER George Schwab | ADDRESS 1401 Eutaw Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EC 10 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Result of Rheumatism
30 yrs ago

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81639

CERTIFICATE OF DEATH.

118 D 81639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary C. Schellhause

(a) RESIDENCE NO. 1117 Battery ave ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Henry W. Schellhause

6 DATE OF BIRTH (month, day, and year) March 11, 1864

7 AGE — Years: 59 Months: 8 Days: 29. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John Simon Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Portz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Hospital Records

15 DEC 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1923, to Dec 10, 1923, that I last saw h[illegible] alive on Dec. 10, 1923 and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia -

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Dec 7, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. Hundley M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 12 1923

20 UNDERTAKER: A Howard Evans — ADDRESS: 1438 St. Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81640

CERTIFICATE OF DEATH.

90 D 81640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2418 (Street) Fait Ave (Ward) 1

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmidt

(a) RESIDENCE. No. 2418 (Usual place of abode) St., Fait Ave Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmidt

6 DATE OF BIRTH (month, day, and year) Sept. 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	63	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Schmidt (Address) 2418 Fait Ave.

15 DEC 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 1923 to Dec 8 1923

That I last saw him alive on Dec 6 1923

and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Chr. endocarditis & Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 7 mos. 16 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/8. 1923 (Address) 2002 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	Dec 12 1923

20 UNDERTAKER ADDRESS

N. Gander & Sons 1710 Eutaw St.

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 81641

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 511 N. Central ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Cummings

(a) RESIDENCE NO. 511 N. Central ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X		1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Chas Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Helen Seaborn

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Va

14 Informant Chas Cummings (Address) 511 N. Central Ave.

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1923, to Dec 9, 1923, that I last saw her alive on Dec 9, 1923 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. McCabe M. D.

12/11, 1923 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Dec 11 19

20 UNDERTAKER Chas. A. Johnson ADDRESS 46 N. Carolina St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81642

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1503 Braddish Ave. ST., 16 WARD)

2-FULL NAME John Bernard O'Donnell

(a) RESIDENCE NO. 1503 Braddish ST., Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie C. O'Donnell

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transportation 009

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk. Retired

(c) Name of employer Merchants & Miners.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Bernard O'Donnell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Charles O'Donnell

(Address) 1503 Braddish ave

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from August 17, 1923, to December 8, 1923, that I last saw h... alive on December 8, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Auto-intoxication

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coulahan, M. D.

12/10 1923 (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Dec 12 1923
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	Balto Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81643

100-001

D 81643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Weinstock

(a) RESIDENCE NO. 105 N. Bond ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abram Weinstock

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Ru

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 Eutaw St

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1923, to Dec. 10, 1923, that I last saw h e alive on Dec 10, 1923, and that death occurred, on the date stated above, at 2:25 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis, arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A Yaskin, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Woodlawn Cem. DATE OF BURIAL 12/11 1923

20 UNDERTAKER Jack Lewis 1439 Eutaw St ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81644

CERTIFICATE OF DEATH.

101-001

D 81644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Orleans ST., 6 WARD)

2-FULL NAME John A. Plumhoff

(a) RESIDENCE NO. 1504 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 2 '78

7 AGE — Years: 45 Months: 6 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chemical

(b) General nature of industry, business, or establishment in which employed (or employer): Tester

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry G. Plumhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen E. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ellen E. Plumhoff

(Address): 1504 Orleans St

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923, to Dec 9, 1923, that I last saw him alive on Dec 7, 1923 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tabardjmmmmm

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

12-10, 1923 (Address) 120 Virginia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathias — DATE OF BURIAL: Dec 12 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 81645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-001

D 81645

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. George A Hampton

(a) RESIDENCE NO. 1109 St Paul ST., ... WARD .....

(Usual place of abode) Tupelo Miss

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1889

7 AGE: Years 34 ? Months ..... Days 14 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 054

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Oxford Miss.

PARENTS

10 NAME OF FATHER Walburn W. Hampton

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Miss.

12 MAIDEN NAME OF MOTHER Victoria Gardner

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Miss.

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Dec 11 1923 ROBERT R. KRAUTER, Registrar

DEC 11 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 10, 1923, that I last saw him alive on Dec 10, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1109 St Paul St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture.

(Signed) Trevor Owen, M. D.

, 19 (Address) Johns Hopkins Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tupelo Miss

DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: John O Mitchell

ADDRESS: 1201 W Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

in O.

Spec. 7-10-21—M&T—1500 Bks.

D 81646 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital — 74-00

CITY OF BALTIMORE: (No. 15 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Wolf Foor

(a) RESIDENCE NO. 1614 Moreland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 76 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Michel Foor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): N. Baker 1614 Moreland ave

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/11 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/31, 1923, to 12/11, 1923, that I last saw him alive on 12/11, 1923 and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Embolism or Hemorrhage of Rt. lenticulo-striate artery. (Cerebral Apoplexy)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardio-vascular-renal syndrome (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidor L. Jay, M. D.

Dec. 11 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL 12/11 1923

20 UNDERTAKER: Abe Levinson & Bro — ADDRESS E Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Byers—1-10-21—MAT—1500 Blks.

D 81647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81647

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 McHenry ST., 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Mynar

(a) RESIDENCE NO. 2519 McHenry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? —yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed Mynar

6 DATE OF BIRTH (month, day, and year) June 5/1901

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
22	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER John F Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estella E Hutchins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas F Townsend

(Address) 2519 McHenry St

Filed DEC 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 8, 1923, that I last saw h-- alive on Dec 7, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

What test confirmed diagnosis? No

(Signed) Harold W Jones M. D.

19 (Address) 222 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley

DATE OF BURIAL Dec 11 1923

20 UNDERTAKER F. B. Kupfrian

ADDRESS Frd'k

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81648

CERTIFICATE OF DEATH.

× 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 E. Balto St. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Henry Young

(a) RESIDENCE No. 2800 E. Balto ST., WARD Pantcoke Md

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary R Young

6 DATE OF BIRTH (month, day, and year): Aug 1 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 46

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Pantcoke Md.

PARENTS

10 NAME OF FATHER: William Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pantcoke Md.

12 MAIDEN NAME OF MOTHER: Mary Hannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary Young. (Address): 2800 Balto St.

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 11 1923

17

I HEREBY CERTIFY, That I attended deceased from May 5 1923, to Dec 10 1923, that I last saw her alive on Dec 10 1923 and that death occurred, on the date stated above, at 6.20 am

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray.

(Signed) [illegible] M. D.

12/11/23 (Address) 2958 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pantcoke Wicomico Co. Md. DATE OF BURIAL: Dec 11 1923

20 UNDERTAKER: William C. Black ADDRESS: 927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 ANT 1800 Blks.

168028

D 81649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D 81649

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6 WARD)

CITY OF BALTIMORE: (No. ..... ST., ...

2-FULL NAME John R. Smith

(a) RESIDENCE NO. 1901 E. Fairmount Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Smith

6 DATE OF BIRTH (month, day, and year): Sept 10 1849

7 AGE: Years 74 Months 2 Days 29 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Collar Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anne —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed DEC 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1923 to Dec 9, 1923, that I last saw him alive on Dec 9, 1923, and that death occurred, on the date stated above, at 12.40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) yrs. mos 10 minutes ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency and Senile Psychosis (duration) yrs. one year or more mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? Yes autopsy

What test confirmed diagnosis?

(Signed) H. Wells M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery DATE OF BURIAL 12/12 1923

20 UNDERTAKER: Chas. S. Evans & Son ADDRESS 118 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81650

CERTIFICATE OF DEATH.

3/ B 81650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 638 Cokesbury ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Benedict Green

(a) RESIDENCE. No. 638 Cokesbury Ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. & Construct.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester, Pa.

PARENTS

10 NAME OF FATHER William Green.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Catherine Murphy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Florence McWhorter (Address) #638 Cokesbury Ave.

15 Filed. DEC 11 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jany 15, 19 23 to Dec. 11, 19 23

that I last saw him alive on Dec. 11, 19 23

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal & pulmonary tuberculosis

(duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George Abner Barden, M. D.

12/13 1923 Address 151 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chesterlown Md	12/13 1923
20 UNDERTAKER	ADDRESS
Henry W. Meas & Son	1052 N. Calvert

Via Md. Del & Va. R.R. to's Steamer - Mrs Charles A McWHORTER, Escort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 81651

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. Mary Vincent. (McCormick)

(a) RESIDENCE NO. 13 S. Eppleton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .065

(b) General nature of industry, business, or establishment in which employed (or employer) Sister of Mercy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record

(Address)

15 Filed DEC 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/23 19

17

I HEREBY CERTIFY, That I attended deceased from 12/6/23, 19, to 12/10/23, 19,

that I last saw h alive on 12/10/23, 19,

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt St Agnes Cem. Mt Washington	12-12 1923
20 UNDERTAKER	**ADDRESS**
C & B Hart	1156 West St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81652

CERTIFICATE OF DEATH.

D 81652

1-PLACE OF DEATH

Registered No. 114

City of BALTIMORE: (No. 505 S Madeira St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Heaphey

(a) Residence No. 505 S Madeira St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of child

6-DATE OF BIRTH (month, day and year) Oct 11, 1916

7-AGE. 7 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Girl

(b) General nature of industry, business, or establishment in which employed (or employer). do

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Harry Heaphey.

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER, Rose Andrzejewski

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country),

14- (Informant) Harry Heaphey

(Address) 505 Madeira

15- Filed DEC 11 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923 to Dec 9, 1923.

that I last saw her alive on Dec 8 1923.

and that death occurred, on the date stated above, at 6 55 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reufschneider M. D.

12/10, 1923 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus, DATE OF BURIAL, Dec. 14, 1923.

20-UNDERTAKER. W. F. Sadowski. ADDRESS 505 S. Ann St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81653

172-06

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2901 Orleans ST., 6 WARD)

2-FULL NAME John A. Forster

(a) RESIDENCE NO. 2901 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Forster

6 DATE OF BIRTH (month, day, and year): Nov. 7-1858

7 AGE — Years: 65 — Months: 1 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Fitter

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Michael Forster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Mary E. Shoemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Barbara Forster

(Address): 2901 Orleans st.

15 Filed DEC 1 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): dec 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923, to Dec 7, 1923, that I last saw him alive on Dec 8, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? dont.

(Signed) C. Kan Jonley, M. D.

, 19 (Address) 2938 Walk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec. 12 1923

20 UNDERTAKER: Jos. J. Herr & Son — ADDRESS: 156 N. Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS to record state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Delser)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81654

CERTIFICATE OF DEATH.

X188 D 81654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet S. Delser

(a) RESIDENCE NO. Fulhenwelder ms' ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Sngl'e

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md'

PARENTS

10 NAME OF FATHER Benj' Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Wm. H. Chaney 1130 Calhoun Street

15 Filed , 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

C 11923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held on ~~(Inquest, autopsy)~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Leg Fractured Arm & possibly Fractured Skull

(Duration) a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by Auto'

(duration) yrs. mos. ds.

(Signed) W K Jones M. D.
(Coroner)

12-11 1923 (Address) 1111 Sanford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ruxton, Md. DATE OF BURIAL 12/13/23

20 UNDERTAKER George T. A. Gibson ADDRESS 335 Druid Hill

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31655

CERTIFICATE OF DEATH.

90 D 31655

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1015 W. 37th St.: 13th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann O'Connor

(a) RESIDENCE. No. 1015 W. 37 ST., 13th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John O'Connor

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	95			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) County Sligo Ireland

PARENTS

10 NAME OF FATHER Luke O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. E. Beachboard (daughter)
(Address) 1015 W. 37th St.

15 Filed Dec. 19, 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

EC 111923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-1923

17 I HEREBY CERTIFY, That I attended deceased from 11-14-, 1923, to 12-10-, 1923, that I last saw h... alive on 12-10-, 1923, and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Paul Strumia, M. D.

Dec. 20, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL Dec. 13 1923

20 UNDERTAKER Margaret D. Flynn ADDRESS 1412 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81656

CERTIFICATE OF DEATH.

X 1000 1001 D 81656

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Lemmon ave. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annis May Jones.

(a) RESIDENCE. No 1126 Pennsylvania Ave. WARD. Atlanta Ga.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	One.	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nursing

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Atlanta Georgia

PARENTS

10 NAME OF FATHER Ernest Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carolina

12 MAIDEN NAME OF MOTHER Pearl Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Pearl M. Logan Jones

(Address) 1126 Pennsylvania Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

EC 11 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Dec 11 - , 1923, that I last saw h[illegible] alive on Dec. 10 - , 1923, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(over)

.....(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of .....

Was there an autopsy? No Bacteriological Exam

What test confirmed diagnosis? Physical Examination

(Signed) I Bennett Large, M. D.

, 19 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-12 1923
20 UNDERTAKER	ADDRESS 716
David Easton	8 a m

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure." "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D 81657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 81657

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital (St.) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Fugate

(a) RESIDENCE NO. 1733 Duncan (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17a yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Fugate

6 DATE OF BIRTH (month, day, and year) Jan - 15 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47		10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Donnell

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James P. Fugate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C Mumney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elmer H. Fugate (Address) 1838 E. Biddle

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1923, to Dec 9, 1923, that I last saw h / alive on Dec. 9, 1923, and that death occurred, on the date stated above, at 9:50 m.

The CAUSE OF DEATH* was as follows:

(a) Hemiplegia Paralysis

(duration) yrs. 2 mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/18/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) A. Howard Mason M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/12 1923

20 UNDERTAKER W D Cook

ADDRESS 501 E Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

C 11 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pott Tuberculosis

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1681-2 D 81658

CERTIFICATE OF DEATH.

1002 ✓ 118 D 81658

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mary Thomas

(a) RESIDENCE NO. 1004 Church St. Norfolk St. Va WARD Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 - 1897

7 AGE: Years 26 Months 10 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Elvira Gundy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 DEC 11 1923 . 19 Registrar

Robert P. Hartigan, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 - 1923 to Dec 11 - 1923.

that I last saw h alive on Dec 11 - 1923.

and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Gangrenous intestine

Five weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Strangulated at home

Did an operation precede death? yes Date of Dec 3, 1923

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Aspd Blalock M. D.

Dec 14 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D C

DATE OF BURIAL: Dec 13 1923

20 UNDERTAKER: Ebenezer Allen

ADDRESS: 1617 Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81659

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sqr. Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H Schofield

(Residence in Baltimore: No. 16 S Carey St.; yrs., 67 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

6-DATE OF BIRTH: July (Month) 17 (Day) 1856 (Year)

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor Odd
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: ann allison

13-BIRTHPLACE OF MOTHER, (State or Country): Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs annie Evans

(Address) 16 S Carey st

DEC 12 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 9th (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull
Auto accident

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) C C Wade M. D.

(Coroner)

Dec. 11th 1923 (Address) 143 W Mt Royal

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedarhill Cemetery

DATE OF BURIAL, Dec 12 1923

20-UNDERTAKER, Robert Brookes Son

ADDRESS Cor Calhoun Fayette

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stan—12-23-21—E.B.R.S.—400 Blks.

B 81660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 B 81660

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Penna. Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frieda Wiener

(a) Residence No. 1709 Penna Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice Wiener

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14 (Informant) H Wiener

(Address) 1709 Penna Ave

15 Filed DEC 12 1923 ROBERT R. KRAUER, Registrar. Burial Permit issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-11-23

17- I HEREBY CERTIFY, That I attended deceased from ....., 1923 to Dec 11, 1923, that I last saw h.. alive on Dec 11, 1923, and that death occurred, on the date stated above, at 7.50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Myocarditis

(Duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhage 6 hours

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank R. Smith M. D.

12, 12, 1923 (Address) 927 N. Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Krong Rest

DATE OF BURIAL. Dec. 12, 1923

UNDERTAKER. Jack Lewis,

ADDRESS 1439 E. Balto.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms): *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably Cancer of Stomach

Spec.—1-10-21—M&T—1500 Bks.

D 81661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81661

91-0020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Homewood Hosp. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane S. Williams

(a) RESIDENCE NO. Homewood Hosp. ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? 86 yrs. 3 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug-11-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	86	3	28	

8 OCCUPATION OF DECEASED 068

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) School Teacher.

(c) Name of employer (none)

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Abner Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ? ? Mass.

12 MAIDEN NAME OF MOTHER Semanthe Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Williamsburg Mass.

14 Informant Mrs L. L. Fetterhoff (Address) Homewood Hosp.

15 Filed DEC 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Dec 9, 1923

that I last saw h alive on Dec 9, 1923

and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows: Cerebro Embolism

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lloyd Fetterhoff M. D.

19 (Address) Homewood Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Dec 12 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81662

CERTIFICATE OF DEATH.

162 D 81662

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maly Hosp St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby girl Baum

(Residence in Baltimore: No. West End Maly St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) —

6-DATE OF BIRTH, 12 (Month) 11 (Day), 1923 (Year)

7-AGE, ✓ ....yrs. ....mos. ....ds. If LESS than 1 day, ½ hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), West End Maly

PARENTS.

10-NAME OF FATHER, Theo Baum

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Edna Schwartzberg

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theo Baum

(Address) 172 Pressbury St

15- Filed DEC 12 1923, 19.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12 11 1923, to 12 11 1923, that I saw h ~~alive~~ dead on 12 11 23 191..., and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. S. Kolodny M. D.

Dec 11, 1923 (Address) 1515 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sinai Mt Carmel — DATE OF BURIAL, Dec 12 1923

20-UNDERTAKER Mat Jonson — ADDRESS 127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81663

100-001 D 81663

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 Barclay ST., 12 WARD)

2-FULL NAME Mary Flynn

(a) RESIDENCE NO. 2429 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: late Michael J. Flynn

6 DATE OF BIRTH (month, day, and year): March 17 1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
83	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: James O'Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mr James Flynn
(Address) Washington D. C.

15 Filed DEC 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 17 1923 to Dec 12 1923,

that I last saw her alive on Dec 12 1923,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hanson M. D.

12/12 1923 (Address) 7006 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cemetery Texas md.

DATE OF BURIAL: Dec. 14 1923

20 UNDERTAKER: Henry Hoeck Son

ADDRESS: 1401 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81664 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81664

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Davis

(a) RESIDENCE NO. 1219 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE Blk.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Wesley L. Davis

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE 25

Years	Months	Days	If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital Balto. Md.

15 Filed DEC 12 1923 Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9. 1923 to Dec 9. 1923

that I last saw her alive on Dec 8. 1923

and that death occurred, on the date stated above, at 8.48 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) A. J. Edmunds M. D.

12/ 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge md

DATE OF BURIAL Dec 12 1923

20 UNDERTAKER Edward Bryon

ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81665

CERTIFICATE OF DEATH.

90 D 81665

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Towson St. ST., 24 WARD)

2-FULL NAME Irene Karasek.

(a) RESIDENCE No 1206 Towson St. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? 10 yrs. ----- mos. ----- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed or divorced
(Or) WIFE of Charles Karasek.

6 DATE OF BIRTH (month, day, and year) March 16, 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER John Stoad.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary.

14 Informant Charles Karasek. (husband)
(Address) 1206 Towson st.

15 Filed DEC 12 1923 192 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Dec, 11, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 3 1923
20 UNDERTAKER Jno. F. Eva & Son	ADDRESS N. Charles

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-1921—M9TI 50M46

D 81666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 81666

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. University Hosp ST., 25 W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Klara Novotny.

(a) RESIDENCE NO. 711 Curtis Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Novotny.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Jelinek.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant deceased Klara Novotny
(Address) 711 Curtis Ave

15 Filed DEC 12 1923, 19 ROBERT P. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Novem 14, 1923, to Dec 11, 1923,

that I last saw him alive on Dec. 11, 1923,

and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Staphylococcic Septicemia

Multiple purulent foci (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) W. Hoover Jr, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Dec 13 1923

20 UNDERTAKER Frank Davidson — ADDRESS 1906 Eastlord

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81667

CERTIFICATE OF DEATH.

74-601

D 81667 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Guilford Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Custis

(a) RESIDENCE NO. 1801 Guilford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va

PARENTS

10 NAME OF FATHER William Bake Custis

11 BIRTHPLACE OF FATHER (city or town) Accomac Co Va (State or country)

12 MAIDEN NAME OF MOTHER Eliza L Henry

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co Md (State or country)

14 Informant Sarah E. Custis (Address) 1801 Guilford Ave.

15 DEC 12 1923 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17

I HEREBY CERTIFY, That I attended deceased from March 19 23 to Dec 11 19 23

that I last saw her alive on Dec 7 19 23

and that death occurred, on the date stated above, at abt 6 A. m.

The CAUSE OF DEATH* was as follows:

cerebral hemmorhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration Several yrs.) hem. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B.P.

(Signed) Grover Hall M. D.

12/11 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Allegany Co	12/13 1923

20 UNDERTAKER A H Jenkins & Sons ADDRESS Mt Calvary Cumberland

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21 E.B.R.S.—400 Blks. 81773

D81668 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D81668

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 21 S. Stricker St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Belle Scott

(a) Residence No. 21 S. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Roger W. Scott

6-DATE OF BIRTH (month, day and year): Sept 20 1854

7-AGE: 69 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS.

10-NAME OF FATHER: Wm. Caudle

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Mary =

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14-(Informant): Eva A. O'Connor

(Address): 21 S. Stricker St.

Filed DEC 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 15-23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Dec. 15, 1923, that I last saw h[illegible] alive on Dec 1923, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): cerebral hemorrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Hennessy M. D

Dec. 15, 1923 (Address) 2802 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va

DATE OF BURIAL, Dec 16 1923

20-UNDERTAKER: John Mitchell

ADDRESS: 1031 Lafayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—E.B.P.S.—400 Blks.

D 81669

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

100 D 81669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5 N Collington Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fiwel Klotzman

(a) Residence No. 5 N Collington Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug Sept 22/1923

7-AGE. yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Ben Klotzman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Lilly Kimmel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E Balto St

15-

FILED DEC 12 1923 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/11/23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11 19 23 to Dec 11 19 23

that I last saw him alive on Dec 11 19 23

and that death occurred, on the date stated above, at 10 55 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hubert Boyle, M. D.

12/12, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Waun'l	12/14, 19 23
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1 10 21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81670

CERTIFICATE OF DEATH.

12/9 D 81670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Budget Ward.

(a) RESIDENCE NO. 719 S Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Ward.

6 DATE OF BIRTH (month, day, and year) 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Mahoney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Budget Grumley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Hospital Records.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/23 19

17

I HEREBY CERTIFY, That I attended deceased from 11/6/23 ..., 19 ..., to 12/10/23 ..., 19 ...,

that I last saw h alive on 12/10/23 ..., 19 ...,

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Harf. Rd. DATE OF BURIAL: Dec 13 1923

20 UNDERTAKER: F. A. Krause & Son ADDRESS: 703 Hanover

DEC 12 1923 ROBERT R. KRAUTER, REGISTRAR OF VITAL STATISTICS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 81671

CERTIFICATE OF DEATH.

100 D 81671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Hanover ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Brown

(a) RESIDENCE NO. 626 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct, 15 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	—	1	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Britton Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorie Maryland.

12 MAIDEN NAME OF MOTHER Edna Leisure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co Maryland.

14 Informant (Address) Britton Brown 626 S. Hanover

15 Filed ..... 19 ..... Registrar

DEC 12 1923

ROBERT P. KRAUT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/8, 1923, to 12/10, 1923,

that I last saw h alive on 12/10, 1923,

and that death occurred, on the date stated above, at 11 a, m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia (Primary)

(duration) — yrs — mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Dan Strauchen M. D.

12/10 1923 (Address) 822 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cosville Md	Dec 12 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	783 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81672

CERTIFICATE OF DEATH.

90 D 81672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 First, ST., W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Smolinske

(a) RESIDENCE (No. 1609 First ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Smolinski

6 DATE OF BIRTH (month, day, and year) Sept 10 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Smolinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Smolinski Jr

(Address) 213 S Eutaw Ave

15 Filed DEC 12 1923 192 EUGENE R. KRAUTER, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broken Constitution

(duration) yrs. mos. 1 ds.

(Signed) Geo. E. Blades, M. D.

(Coroner)

Dec 12, 1923 (Address) 1473 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross German Hill — DATE OF BURIAL: Dec 13 23

20 UNDERTAKER: John A Weber — ADDRESS: 1803 Bank St

Spec. 1-10-21—M&T—1500 Blks.

D 81673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 23 WARD)

2-FULL NAME Thomas Tillman

(a) RESIDENCE NO. 917 Peach Alley ST., ... WARD ...
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Unknown ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed DEC 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from December 6, 1923 to December 9, 1923, that I last saw h in alive on December 8, 1923, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia
Cerebral Softening (right side) 087

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Terminal) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harry E. Handley, M. D.

12-10-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Dec 12 1923
20 UNDERTAKER	ADDRESS
Mrs Gotthelf	Mt Carmel

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

~~Corpulent~~

Diuetic

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31674

CERTIFICATE OF DEATH.

D 31674

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie May Bean

(Residence in Baltimore: No. 218 N Madison St.; yrs. 10 mos. ds.)

EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: January 21 1854
(Month) (Day) (Year)

7-AGE: 49 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerical
(b) General nature of industry, business, or establishment in which employed (or employer): Physician

9-BIRTHPLACE, (State or Country): Washington D C

PARENTS:

10-NAME OF FATHER: Geo H Dreshaur

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Minnie Selby

13-BIRTHPLACE OF MOTHER, (State or Country): Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos N Dreshaur

(Address) 218 N Madison St

15-

Dec 12 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11/23
(Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinomatous Tumor of Brain

(Autopsy at Hospital)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(Duration) 8 yrs. ....mos. ....ds.

(Signed) J S Bloom M. D.
(Coroner.)

Dec 22 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington D C DATE OF BURIAL, Dec 13 1923

20-UNDERTAKER, Thos Kraucr Sons ADDRESS North Ave